PT, OT, ST
PRECERT FORM

VIVA HEALTH, Inc.
417 20th Street North, Suite 1100
Birmingham, Alabama 35203
Phone: (205) 933-1201
Fax: (205) 449-7049

Please fax this form with all applicable information documented.
A review can NOT be completed without the necessary information.

Please return this form to:
VIVA HEALTH, Inc.
Fax: (205) 449-7049

VIVA HEALTH USE ONLY
☐ Medicare
☐ Commercial
☐ VIVA MEDICARE *Me*

Contract Number (include suffix):	Group Number:	Subscriber Name (last, first, middle initial):
Patient Name (last, first, middle initial):	Date of Birth:	Referring Physician's Name (first and last):
NPI:	P.T. Office Fax Number:	P.T. Facility Name:
P.T. Address:		P.T. Telephone:

Primary ICD-10 Code: Onset Date:	Secondary ICD-10 Code (do not use V code): Onset Date:

Check all that Apply:

Surgery ☐ Yes ☐ No	Date of Surgery:	Type of Surgery:
Injury ☐ Yes ☐ No	Date of Injury:	Type of Injury:

Has patient had previous therapy for this condition? ☐ Yes ☐ No — **If yes,** date:

List medical or surgical complications and date related to current treatment: ____

____

____

LIST ALL DATES OF SERVICE FOR THE CURRENT CALENDAR YEAR

1	2	3	4	5	6	7	8
9	10	11	12	13	14	15	16
17	18	19	20	21	22	23	24
25							

☐ Initial Certification
______________Current MD Referral
______________Number of visits requested for this Certification
______________Projected End Date of therapy

☐ Additional Certification
______________Current MD Referral
______________Treatment Notes from previously certified visits, exercise flow sheets. Documentation should include objective findings/functional limitations, updated goals, progress towards goals, current treatment plan, and any additional information from last certified visit to support medical necessity for additional visits.
______________Number of visits requested for this Certification
______________Projected End Date of therapy

Please document changes in treatment plan and/or the patient's condition to warrant the course of treatment.