



Workers' Compensation PPO Patient Management Record

Provider: Upon completion of the information below, please fax (607) 762-2433 or toll-free (866) 234-8753.

★ REQUIRES COMPLETION BY PROVIDER.

Provider Name & Location (Please Print)			Appointment Date: _____/_____/____	Time: _____:_____ am/pm
Patient Name:	SS #:	ICD-9 Code: ★	Injury Date: _____/_____/____	Initial Visit Date: _____/_____/____
★ Office Procedure Codes - (CPT4):				
★ Diagnosis:			Employer:	
Patient Description of Injury:				
★ Treatment Rendered:				

CPT CODING INFORMATION

★ **Patient Profile** New Patient Established Patient **Type of Visit** Brief Limited Intermediate Comprehensive

RECOMMENDATIONS

★ Patient may return to work full duty. <input type="checkbox"/> YES <input type="checkbox"/> NO		
★ First Day of Disability _____/_____/____	Is Patient Working? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the patient disabled from regular duties? <input type="checkbox"/> YES <input type="checkbox"/> NO
★ Disability: <input type="checkbox"/> NONE <input type="checkbox"/> TOTAL <input type="checkbox"/> Partial Disability please <input checked="" type="checkbox"/> <input type="radio"/> mild <input type="radio"/> moderate <input type="radio"/> marked	Has patient reached Maximum Medical Improvement? <input type="checkbox"/> YES <input type="checkbox"/> NO	If no, when will the patient be seen again? Date: _____/_____/____ Time: _____
Functional Work Capabilities: ___ NO Bending Stoopng Twisting Squatting Kneeling Lifting Pushing Pulling Climbing Crouching Over Head Work Repetitive Wrist Motion ★ ___ One Hand/One Arm Work (<u>Right</u> or <u>Left</u>) ___ May Lift Up To _____ lbs. <input type="checkbox"/> occasionally (33%) <input type="checkbox"/> frequently (66%) <input type="checkbox"/> continuously (100%) of work day ___ May Pinch/Grip <input type="checkbox"/> occasionally (33%) <input type="checkbox"/> frequently (66%) <input type="checkbox"/> continuously (100%) of work day ___ Other		

FOLLOW-UP CARE

* Referral & Authorization Requests:
* Comments/Justification:
* The injury is causally related to work. <input type="checkbox"/> Yes <input type="checkbox"/> No I hereby certify that the aforementioned information is true and correct to the best of my knowledge.
* Date: _____ / _____ / _____
Signature of Provider _____

UOM CASE MANAGER USE ONLY

Date & Time of Company Notification: Date: _____/_____/____ Time: _____:_____
Spoke With (Name): _____ Comments: _____

Returned To Work YES NO **Case Manager Signature:** _____

DATE & TIME FAXED TO EMPLOYER _____
DATE & TIME FAXED TO CARRIER _____