Patient Summary Form PSF-750 (Rev: 7/1/2015)			Instructions Please complete this form within the specified timef
PSF-750 (Rev: 7/1/2015) Patient Information			All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless oth wise instructed.
	O Fem		Please review the Plan Summary for more informat
Patient name Last First	MI Male	Patient da	e of birth
Patient address	City		State Zip code
Patient insurance ID#	Health plan		Group number
Referring physician (if applicable)	Date referral issued (if applicab	le)	Referral number (if applicable)
Provider Information			
Name of the billing provider or facility (as it will appear on the claim	m form)	2. Federal tax ID	(TIN) of entity in box #1
			nd OT 6 Home Care 7 ATC 8 MT 9 Other —
3. Name and credentials of the individual performing the service		. 🕂 🖒	
4. Alternate name (if any) of entity in box #1	5. NPI of entity in	1 box #1	6. Phone number
7. Address of the billing provider or facility indicated in box #1		8. City	9. State 10. Zip code
Provider Completes This Section:		Date of Su	rgery Diagnosis (ICD codes)
Date you want THIS			Please ensure all digits are entered accurately
	of Current Episode		1°
(1) Traumat	X	Type of Surge	-
Patient Type (2) Unspecification (2) Repetitive	×	(1) ACL Reconstruction (2) Rotator Cuff/Lat	Z
(1) New to your office	o (b) Motor Vollidio	(3) Tendon Repair	
2 Est'd, new injury		(4) Spinal Fusion	3°
3 Est'd, new episode		5 Joint Replacem	ent 4 °
Est'd, continuing care		6 Other	
Nature of Condition	DC ONLY]	Current Functional Measure Score
1) Initial onset (within last 3 months)	Anticipated CMT Level		
2 Recurrent (multiple episodes of < 3 months)	98940 98942	Neck Inc	DASH (other FOM)
(3) Chronic (continuous duration > 3 months)	98941 98943	Back Inc	
Patient Completes This Sections		•	
	oms began on:		Indicate where you have pain or other symp
(Please fill in selections completely)			
1. Briefly describe your symptoms:			Cird Co
			I WE AN MY. MY
2. How did your symptoms start?			1/(1)/2//2/
3. Average pain intensity:			The work the last
Last 24 hours: no pain 0 1 2 3	(4) (5) (6) (7) (8) (9)	10) worst pain	
Past week: no pain 0 1 2 3	4 5 6 7 8 9) (10) worst pain	1 \11 \11
4. How often do you experience your sym	otoms?		
(1) Constantly (76%-100% of the time) (2) Frequen	tly (51%-75% of the time) (3)	Occasionally (26% - 50%	of the time) 4 Intermittently (0%-25% of the time)
5. How much have your symptoms interfer	red with your usual daily	activities? (including	g both work outside the home and housework)
1 Not at all 2 A little bit 3 Mode	erately $igg(4igg)$ Quite a bit $ig($	5 Extremely	
6. How is your condition changing, since			
0 N/A — This is the initial visit 1 Much	worse 2 Worse 3 A little	worse 4 No chang	e (5) A little better (6) Better (7) Much bette
7. In general, would you say your overall	health right now is		-
(1) Excellent (2) Very good (3) Goo	- ^	5) Poor	
Patient Signature: X	· ·		Date:
v.g			