



Department of Health and Human Services
 MaineCare Services
 Prior Authorization Unit, Physical/Occupational/Speech Therapies
 11 State House Station
 Augusta, Maine 04333-0011
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Request for Prior Authorization of Physical Therapy Services for Treatment of Chronic Pain
 Participation in Therapy to alleviate chronic pain

This form must be completed by a physician/PCP and submitted to a Physical Therapy (PT) provider. The PT provider must submit this completed form along with request for PT services authorization.

MaineCare Benefits Manual, Chapter 2, Section 85, Physical Therapy Services, covers up to six (6) Physical Therapy visits (one evaluation visit and five treatment visits) for management of long-term non-acute pain.

Member's Name _____ MaineCare ID# _____

Birth Date _____ Diagnosis _____ ICD Diagnosis Code _____

1. Is this referral part of a treatment plan for diagnosed long-term non-acute pain? (Non-acute pain is any pain that has lasted, or is expected to last, more than 60 days and impacts/is expected to impact a member's level of function for more than 60 days.) (Must check one)
 - Yes (see below)
 - No (If no, patient does not qualify for Physical Therapy six visits for evaluation and treatment of chronic pain. Patient may qualify for one evaluation visit and one treatment visit; refer to PT provider.)

If yes, when did the patient's pain begin? What condition is causing the pain? Please describe or attach office notes.

2. This member has the following conditions: (additional information, if applicable)
 Pain present greater than 60 days and has:
 - Medical visits >2 for the same pain diagnosis within a 60 day period
 - Patient reports loss of work for greater than 2 weeks related to this condition

3. Risk Assessment
 - A. Is this patient program intended to prevent the use of narcotics/opioids?
 - Yes
 - No
 - B. Is this patient program intended to reduce or eliminate the current use of narcotics/opioids?
 - Yes
 - No

(cont., pg. 2) Patient Name _____

4. Is this referral for a Chronic Pain Management Program for narcotics/opioids, in accordance with Section 80.07, Pharmacy Services?

- Yes
- No

Section 85, Physical Therapy Services, covers up to six (6) Physical Therapy visits (one evaluation visit and five treatment visits) for management of chronic pain.

This request is for _____ (up to 5) Physical Therapy treatment visits.

Member has 12 months to complete the Physical Therapy treatment.

Date of most recent face-to-face visit with patient: _____

Signature of the physician/PCP prescribing the Physical Therapy services. This patient's medical records are available to the Department upon request.

Physician/PCP Signature: _____ Date: _____

Printed Physician/PCP Name _____ Office Telephone Number _____

[Physical Therapy provider—complete this section at the end of treatment]

Member has participated in Physical Therapy for chronic pain related to the diagnosis above mentioned and has **met/not met** goals.

Physical Therapist's Signature: _____ Date: _____

Printed Physical Therapist Name _____ Office Telephone Number _____