Web (RRS) Template | HEALTHWAYS | **RRS Phone #: 1-888-893-4635**

Healthways WholeHealth Networks – Authorization Template (WEB)

Patient Name: ______________________ **Practitioner Name:** ______________________

Called in by: ______________________ **Date called in:** ____/____/____

1.	**Login to WholeHealthPro**	Enter your login and password
2.	**Access Code**	Enter your access code
3.	**Verify Provider Information**	Update fax as necessary, and click "yes" or "no" to verify correct address.
4.	**Patient's ID Number**	Enter Patient's ID Number
5.	**Patient's Sequence Number**	Enter the Patient's Sequence Number
6.	**Patient's Date of Birth**	___ ___/___ ___/___ ___ ___ ___ M M D D Y Y Y Y
7.	**Start date of the registration (+ or – 7 days)**	___ ___/___ ___/___ ___ ___ ___ M M D D Y Y Y Y
8.	**Identify injury mechanism and presence of any other health insurance coverage as applicable**	Select Auto Accident, Work Related, Other Insurance, or None of the options apply
9.	**Initial Authorization Request or Continuation of the same episode**	Select initial or continuation
10	**If Continuation, enter previous authorization reference number**	Enter previous authorization number
11	**Initial Date of Injury or Date of Onset of Condition**	Enter appropriate date
12	**Initial Date you began treating this patient for this primary diagnosis or condition**	Enter appropriate date
13	**Number of patient treatment visits rendered to this patient over the last 6 months in your office**	Enter appropriate number of visits
14	**Number of patient visits being requested, including initial visit to evaluate patient**	Enter requested number of visits
15	**Number of weeks to complete requested patient visits**	Enter appropriate number of weeks
16	**Primary ICD-9 Diagnosis Code**	Enter using decimals
17	**Secondary ICD-9 Diagnosis Code**	Enter using decimals
18	**Third ICD-9 Diagnosis Code**	Enter using decimals
19	**Is this injury of condition new or recurring?**	Select new or recurring
20	**Rate the patient's restriction performing activities of daily living**	Select rating
21	**Rate the extension of pain on a scale of 1-10 (10 being most severe)**	Select rating
22	**Rate percentage of reduction**	Select a value
23	**Do you have a professional referral for treating this patient?**	Select yes or no
24	**Is this patient's MD/DO co-treating the condition?**	Select yes or no
25	**FRI score between "00" and "40" for today's evaluation**	Enter a number between 00-40, or 99 if the patient did not complete the FRI Tool.
26	**Does the patient have a history of any of the following: Diabetes, Stroke, Cancer, Obesity, Smoker, Chronic Pain > 6 months**	Select all that apply
27	**Verify that information entered is correct and submit authorization.**	Print and maintain a copy of the registration in the patient's file for your records.

When your request is certified, the approved visits must be delivered within the pre-authorized time limits, record the authorization reference:

Authorization Reference #: ______________ Visits Approved: ______ Approved Through: ____/____/____

[You will receive a fax confirmation of the prescreening results]

If the Rapid Response System pre-screen review is unable to certify your care plan request, you will receive a fax indicating the specific information to be submitted for utilization review. This may include a request for medical records or a PCP referral (if required). Use the request form, which is bar-coded for this specific request, as a cover sheet. Behind the cover sheet, please fax clear and legible supporting documentation including: **clinical records with initial history and exam,** diagnostic test results, **treatment notes (in SOAP format) for this episode of care, current and prior FRI outcomes documents, Referral Form** (if required by patient's health plan) and any other relevant clinical findings or pertinent information that will support the present diagnosis(es) to: **703-430-5790.**

FILE THE TREATMENT AUTHORIZATION IN THE PATIENT'S CHART