



Please check type of review being submitted: Concurrent Review Minor

All Approvals Valid for 60 days, Please Complete Form Legibly and Fax to: 888-439-4819

Patient Name: _____ DOB: ___/___/_____ Age: _____ Sex: M/F

Insurance ID #: _____ Occupation: _____

Insurance Plan/Employer: _____

Treating Provider's Name (Print Clearly): _____

Treatment for Accident/Injury: Yes No If Yes, date occurred: _____ Type: Auto Work Other

Prior Acupuncture Treatment in past 12 months: Yes No # of visits in past 12 months: _____

Date of Onset: _____ First Visit: _____ Most Recent Visit: _____

Response to Care: Good Fair Poor Date Discharged from Prior Treatment: _____

Reason (If Known): _____

Diagnosis (ICD #) 1: _____ 2: _____ 3: _____ 4: _____

History of Condition: _____

Subjective Complaints: _____

Objective Findings: _____

Functional Outcome Measures: _____

Treatment Plan: _____

Procedure(s) Requested, list CPT code(s): _____

Retro-Approval Requested: Yes No If yes, reason needed (required): _____

Request Submitted On: _____ Effective Date Requested: _____ (must be within 30 days)

Treating Provider Signature: _____ Date: ___/___/_____ Fax #: _____