PhysMetrics

CHIROPRACTIC
PRETREATMENT CERTIFICATION FORM

Please check type of review being submitted: ☐ Concurrent Review ☐ Minor ☐ Massage

All Approvals Valid for 60 days from date received, 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 Chiropractic 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 (Oswestry, back and neck index, etc.): _____

_____

Treatment Plan: _____

_____

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

If Requesting Massage/Manual Therapy, the following information is *REQUIRED* when covered by patient's plan:

Treatment will be performed by: ☐ D.C. ☐ LMT ☐ Mechanical **Rationale:** _____

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 #:** _____