PhysMetrics

ACUPUNCTURE
PRETREATMENT CERTIFICATION FORM

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 #:** _____