**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 #:** __________________