ACUPUNCTURE

PRETREATMENT CERTIFICATION FORM

Please Complete Form Legibly and Fax to: 888-439-4819

Check type of review being submitted: ☐ Concurrent Review ☐ Minor

---

Patient Name: ____________________ DOB: __________ Age: ____ Sex: ___M / ___ F

Insurance ID #: ____________________ Occupation: ____________________

Insurance Plan/Employer: ____________________

Treating Provider's Name: ____________________ Office Location (if multiple options): __________

Date of Onset: ________________ First Visit: ________________ Most Recent Visit: ______________

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: _______________

Response to Care: ___Good ___ Fair ___ Poor Date Discharged from Prior Treatment: __________________

Reason (If known): ____________________

Diagnosis (ICD #) 1:______________ 2:_____________ 3:_____________ 4:_____________ 5:____________

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): ____________________

Retro-Approval Requested: ___ Yes ___ No *If yes, reason (required):* ____________________

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

Phone#: ________________

Treating Provider Signature: ______________________________ Date: _____________ Fax #: ________________

All approvals valid for 60 days from date received