PhysMetrics

CHIROPRACTIC
PRETREATMENT CERTIFICATION FORM

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

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

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 Chiropractic 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): _____

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 (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