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CHIROPRACTIC TREATMENT PLAN FORM

(Please Print or Type Clearly)

Instructions:

1. This form is to be used after the patient has received 8 (eight) chiropractic treatments during a 12 month period. If the patient has not received 8 (eight) treatments, the form is not required.
2. To request an additional three (3) visits, please fill out the form below and fax to 678-990-0025. The form may also be completed and submitted electronically through the Customer Service Center.
3. If more than 3 additional visits are being requested **OR** if the number of visits requested plus prior visits exceeds 11 treatments in the last 12 months **OR** if this is a retro review (for services that occurred more than 30 days prior to form submission), please submit medical records with Treatment Plan Form. Records required are:
   - Patient application for treatment records,
   - SOAP notes,
   - Exam and re-exam findings, and
   - Doctor's history and consultation records

Note: If all information is not filled out *completely* & *accurately* authorization cannot be approved.

Date: ______________________ Treating Doctor's Name: _______________________________________

Patient Information

Last	First	Middle	DOB
Member ID #	Suffix	Height	Weight

Provider Information

Provider Name		Tax ID #
Phone	Fax	Email

Patient Type (check one): New ____ / Established with new injury/episode ____ / Continuing Care ____

Prior Treatments: How many treatments has patient received during the last 12 months? ______

ICD-10 Codes: What is/are the current diagnosis/diagnoses? _______.____ _______.____ _______.____

Date current condition began	1st visit for current condition	Start date for THIS authorization

1. Number of visits requested ____ over ____ days or _____ weeks. ***(If more than 3, or if prior visits plus this request exceeds 11 visits for year, we will need medical records. See instructions above)***
2. Etiology or cause of current condition? ____
3. What is the patient primary complaint? ____
4. Have you completed the acute phase of treatment? _______. Has the patient been compliant? ________
5. Pain Level: Initial Pain Level (1 – 10 scale) ______ Current Pain Level (1 – 10 scale) ______
6. Percentage of recovery to date? ____________
7. Is there anything about this case that makes it unusual or that may hinder your progress? ____________
____

Signature: ____

Print Name & Title (if other than provider): ____