



Chiropractic Pre-Authorization Request Form

Mail form to: Integrated Health Management, P.O. Box 64668; St. Paul, Minnesota 55164-0668 or
 Fax form to: (651)662-7816 Phone: (651)662-5940 or 1-800-365-2735

Provider Name:		Contact Name/Phone #:	
NPI #:	Provider#:	Address:	
Fax:			
Patient Name:		DOB:	Gender:
Subscriber/Enrollee:		Occupation:	
Identification #:	Group #:	Smoker: Y or N	BP > 140/90 Y or N

Chief Complaint	Chief complaint: _____ Initial date of service: ___ / ___ / _____ Patient's rating on Pain Severity Scale: Phase of care: (circle one): Acute Chronic Recurrent Initial ___ / 10 Current ___ / 10 Date of onset/exacerbation for this diagnosis ___ / ___ / _____ History related to this diagnosis: _____ _____ Diagnosis code(s): Primary: _____ Secondary: _____ Other significant medical/history/treatment information: _____ _____ Number of visits since Jan. 1 st : _____ Has patient seen another chiropractor in this calendar year: Y or N <p style="text-align: center;">***Please attach any additional information to support this request***</p>
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Current Clinical Findings	Location of complaint: _____ Height _____ Weight _____ Blood pressure _____ Ft In Lbs Systolic/Diastolic Medications/supplements: _____ _____ / _____ Graded tenderness/spasms: C: ___ / 5 R or L I: ___ / 5 R or L L: ___ / 5 R or L Other: ___ / 5 ROM Cervical: _____ Thoracic: _____ Lumbar: _____ F ___ / 45 EXT ___ / 45 F ___ / 30 EXT ___ / 20 F ___ / 90 EXT ___ / 25 LLF ___ / 45 RLF ___ / 45 LLF ___ / 45 RLF ___ / 45 LLF ___ / 45 RLF ___ / 45 LR ___ / 80 RR ___ / 80 LR ___ / 30 RR ___ / 30 LR ___ / 45 RR ___ / 45 Pain pattern: _____ Orthopedic findings (X one): ___ Normal ___ Local ___ Radiating ___ Other _____ _____ Neurologic findings (X one): ___ Normal ___ Other _____ Other significant findings: _____
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Treatment Plan	<p style="text-align: center;">***Up to 60 days of treatment may be requested***</p> Treatment plan: _____ visits p/week for _____ weeks, from _____ to _____ _____ visits p/week for _____ weeks, from _____ to _____ _____ visits p/week for _____ weeks, from _____ to _____ Total # of CMT: _____ Total # & type of other therapy: _____ Date of initial exam/re-exam: ___/___/___ Date of x-rays for <u>current</u> diagnosis: ___/___/___ *Include copy of report findings* Exact views taken: _____ Date of most recent <u>previous</u> x-rays: ___/___/___ Exact views taken: _____ Treatment goals: _____ Active care: _____ Estimated duration of treatment for this injury/condition _____
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Chiropractic Pre- Authorization Request Form Instructions

Chief Complaint	Chief complaint	Usually the presenting symptom(s) and the main reason they are seeking care.
	Initial date of service	The first date seen in your office for this complaint.
	Patient's rating on Pain Severity Scale	The patient's rating of their pain on a 1-10 scale (1=low, 10=high).
	Phase of care (circle one)	<u>Acute</u> : this is the first visit for this condition/injury. <u>Chronic</u> : history >1 year for this injury/condition. <u>Recurrent</u> : seen in the past year for this condition/injury
	Date of onset/exacerbation for this diagnosis	The date the patient first noticed symptoms or the symptoms worsened.
	History related to this diagnosis	The events leading up to the onset of symptoms, frequency of symptoms, intensity of symptoms, and aggravating/alleviating factors.
	ICD-9 DX codes:	The primary and secondary diagnosis codes. List the codes, not the narratives.
	Other significant medical/history/treatment info.	List the co-morbidities, length of time for this injury/condition, and other treatments tried, etc.
	Number of visits since Jan. 1 st	Identify the number of visits (not services) for <u>your clinic only</u> .
	Has patient seen another chiropractor in this cal. year?	Circle yes or no for care received in another chiropractic office since Jan. 1 st .
Please attach any additional info. to support this request	Information that <u>further</u> demonstrates abnormality, explains why the patient needs chiropractic care, or explains the benefit patient receives from this care.	

Current Clinical Findings	Location of complaint	Specific area(s) the patient points out as symptomatic.
	Height / Weight / Blood pressure	Record a min. of once a year. Blood pressure: record each visit if hypertensive or on blood pressure medications.
	Medications/supplements	Medications/supplements the patient is currently taking.
	Graded tenderness/spasms	Rate the tenderness and or spasms on a 0-5 scale (0=low, 5=high).
	ROM	Record in degrees the range of motion.
	Pain pattern	Record site or region of pain.
	Orthopedic findings (X one)	Record appropriate orthopedic tests.
	Neurologic findings (X one)	Record appropriate neurologic signs.
Other significant findings	Report conditions to which the complaint(s) is related or secondary to.	

Treatment Plan	X visits p/week for X weeks, from X to X	Requested # of visits (not services) per week for the desired number of weeks. Then list the date span. Use the next line as the requested # of visits change.
	Total # of CMT	The total number of chiropractic manipulative therapies in this treatment plan.
	Total # and type of other therapy	The total number and type of other therapy in this treatment plan (i.e. ultrasound, thermal pack, EMS, etc.)
	Date of initial exam/re-exam	Record date of initial visit or re-evaluation which include a history, exam, and decision making.
	Date of x-rays for <u>current</u> diagnosis/ Exact views taken	Record date of x-rays related to chief complaint List the exact view(s) taken. Include a copy of the report findings.
	Date of most recent <u>previous</u> x-rays / Exact views taken	Record, if applicable, the date for most recent <u>previous</u> x-rays. List the exact view(s) taken. This assists the reviewer in distinguishing sequence of events in care.
	Treatment goals	Document how you expect the patient to respond to care in the short term and long range (i.e. short term goal: relief of pain in 2 visits / long term goal: strengthening the musculature of the upper back in 6 visits) or the maximum improvement expected and in what timeframe.
	Active care	Instruction of the patient in how to care for himself or herself, examples are exercise, weight loss, stress reduction, lifestyle modification, and changes in the work environment
Estimated duration of treatment for this injury/condition	Estimated duration of treatment for this injury/condition. Document the amount of time in days, weeks, or months required for patient to reach improvement.	