

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

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| 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 ***Please attach any additional information to support this request*** | | |
| | 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 T: ___ / 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 | ***Up to 60 days of treatment may be requested*** |
| | 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 _____ | |

**Chiropractic Pre- Authorization Request Form
Instructions**

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| 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. | |

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| 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. |

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| 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. |