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CHIROPRACTIC TREATMENT PLAN FORM

(Please Print or Type Clearly)

Note: If all information is not filled out *completely* and *accurately* this form will be returned without authorization.

Date: ___________________ Network Doctor's Name: ______________________________

Treating Doctor: _____________________________________

Patient Information

Last:	First:	Middle:	DOB:

Member ID #	Suffix	Height	Weight

Provider Information

Provider Name	Federal Tax ID #

Phone	Fax	NPI #

Prior Diagnoses: List primary diagnoses for which you have treated this patient in the last 12 months.

Diagnoses (Past 12 Months)	ICD9 Code	# of Treatments	From (Start Date)	To (End Date)
_________________________	_______.____	_________	___________	___________
_________________________	_______.____	_________	___________	___________
_________________________	_______.____	_________	___________	___________

Current Diagnoses	ICD9 Code
_________________________	_______.____
_________________________	_______.____
_________________________	_______.____

Date Current Condition Began

First Visit for Current Condition

Start date for **THIS** authorization

Patient Type (check one)

- ○ New to your office
- ○ Established Patient, New Injury
- ○ Established Patient, New Episode
- ○ Established Patient, Continuing Care

Number of additional visits requested: _____ over _____days or _____ weeks.

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1. Etiology or cause of current condition? ____
2. What is the patient primary complaint? ____
3. Have you completed the acute phase of treatment? ________ Has the patient been compliant? ________
4. Initial Pain Level (Circle one) – 1 2 3 4 5 6 7 8 9 10
5. Current Pain Level (Circle one) – 1 2 3 4 5 6 7 8 9 10
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): ____