CLINICAL RESOURCE GROUP, INC.
Treatment Authorization Form

Please print or type

Treating Provider: _____Phone # _____

Practice Name: _____FAX # _____

Patient Name: _____DOB _____PMI # _____
(8 digit number)

Patient is: ☐ New to this practice ☐ An established patient

A. All dates of Service for the preceding 12 months in this office: _____

B. Diagnosis: 1. _____ 2. _____ 3._____

C. Reason for Today's Office Visit (describe cause of patient complaint**):** _____

_____

_____

D. Specific Spinal Subluxations: 1. _____ 2. _____

3. _____ 4. _____

E. History of Current Complaint:

1. Date of On-set: _____

2. Site of Pain/Symptom: _____

3. Subjective Complaint: _____

_____

_____

4. Objective Findings: _____

_____

_____

5. Other Complications or Co-Morbidities:_____

F. Treatment plan request:

1. Total number and Level of treatments requested. The Frequency of requested visits and the level of treatment should decrease in frequency and intensity: If greater than 50% of these treatments are 98941, provide clear rationale for treatment at that level and submit all daily notes and clinical findings.

Week	Number of visits	98940	98941	98942
1				
2				
3				
4				
Total				

3. Radiographic Imaging Requested: ☐ Yes ☐ No

If yes, describe the views (CPT codes) requested: _____

Describe rationale for radiographic films: _____

_____

_____

4. Goals of Chiropractic Care: _____

_____

_____

5. Plan to achieve Goals: _____

_____

_____

6. Patient "self care" program. Describe home exercise prescribed and patient education that will assist the patient in the self management of their complaint.

_____

_____

_____

To the best of my knowledge the information provided above is true and accurate. In my professional opinion and best clinical judgment, this request for chiropractic treatment describes a safe and effective treatment plan that will serve to benefit the patient.

Provider Signature _____ Date _____

FAX This form to CRG at 651-633-6547