HealthPartners Medicare/MSHO Chiropractic Treatment Review

Fax: 952-853-8713

Phone for questions: 952-883-6333

Date of this Request_____/_____/_____

Please check type of care:
☐Initial care ☐Continuing care ☐Retrospective Review
☐1st Request after Waiver Program

INSURED

Patient Last Name	Patient First Name	M.I.	Gender ☐ M ☐ F	Age	Date of Birth (MM/DD/YYYY) ____/____/____
Insured I.D. or SSN	Insured Last Name	M.I.	First Name		Patient Phone (area code first)
Patient Address	City		State		Zip Code

PAYOR

Employer Name	Insurance Company	Group Plan # or Union Local (Submit Copy of Patient's Insurance I.D. Card)
Injury or illness is related to: ☐ Work ☐ Auto ☐ Other	Does the patient have other insurance that might cover this injury/illness? ☐ Yes ☐ No	Other carrier's name: ☐ N/A

DOCTOR

Doctor Last Name	Doctor First Name	M.I.	Area Code + Phone ( )	Area Code + Fax ( )
Doctor Address	City	State	Zip Code	Doctor License #

PATIENT'S CURRENT MEDICAL HISTORY

Subjective Complaints:

Lost days from work to date _____ Days of work restriction to date _____

Mechanism of Onset for Primary Diagnosis

Date of Onset (MM/DD/YYYY) ___/___/_____

☐Acute trauma ☐Worsening of prior illness/injury
☐Repetitive motion ☐Gradual onset
☐Chronic ☐Old trauma
Description:

Date of first tx at this office for this condition ____/____/_____

Objective Findings *Date Obtained* ____/____/_____

VITALS: HT: WT: BP: Temp:

Inspection:

Palpation:

Cervical ROM		Lumbar ROM
☐	WNL	☐
____°	Flexion	____°
____°	Extension	____°
____°	R. Lat. Flex	____°
____°	L. Lat. Flex	____°
____°	R. Rotation	____°
____°	L. Rotation	____°

Summary of Examination Findings

1 ☐ Localized pain reproduced on palpation or orthopedic testing (list area) _____
2 ☐ Radiating pain below knee or elbow reproduced on nerve compression or stretch test (list nerve root distribution) _____
3 ☐ Pain referred from muscles or trigger points (list) _____
4 ☐ Diffuse ache on passive motion (list joint/s) _____
5 ☐ Testing revealed pain, swelling or instability of joint or extremity (list) _____
_____
6 ☐ Neurological tests within normal limits
7 ☐ Neurological deficits (describe):

Does the patient indicate that any of these conditions are present on a patient intake form or during your exam?
(please check all that apply)

☐ Articular derangements (arthritides, autoimmune diseases, joint instability or hypermobility, etc.)
☐ History of infection (recent fever >100, constant low-grade fever, bone or joint infection, etc.)
☐ Circulatory or cardiovascular disorders (e.g., stroke)
☐ Bone weakening or destructive disorders (e.g., tumors)
☐ Neurological disorders (myelopathy, acute cauda equina syndrome, multiple sclerosis, etc.)
☐ Atrophy in the extremities
☐ Abnormal deep tendon reflexes or motor weakness
☐ Scoliosis >20 degrees adult or >10 degrees for child
☐ Congenital connective tissue disorders
☐ Abnormal bowel or bladder function
☐ Signs or symptoms of vertebro basilar insufficiency
☐ Fever or localized redness and swelling or ankylosing spondylitis
☐ Signs or symptoms of cancer or chemotherapy tx
☐ Signs or symptoms of organic disease

For any checked items, please attach explanation.

☐ Patient is currently under PCP or medical specialist care; or ☐ referred on ___/___/___

DIAGNOSES

ICD-9 Code (list NMS codes only)	Description	Pain intensity according to patient (None 0 1 2 3 4 5 6 7 8 9 10 Severe)	Symptom frequency according to patient (0-25% / 26-50% / 51-75% / 76-100%)
1. Primary _____	_____	☐☐☐☐☐☐☐☐☐☐☐	☐ ☐ ☐ ☐
2. Secondary _____	_____	☐☐☐☐☐☐☐☐☐☐☐	☐ ☐ ☐ ☐
3. Additional _____	_____	☐☐☐☐☐☐☐☐☐☐☐	☐ ☐ ☐ ☐
4. Additional _____	_____	☐☐☐☐☐☐☐☐☐☐☐	☐ ☐ ☐ ☐

X-RAYS

X-Rays Requested: ☐Yes ☐No **Taken:** ☐Yes ☐No

☐ 3 view cervical, CPT 72040 (AP, APOM, LAT)
☐ 2 view thoracic, CPT 72070 (AP, LAT)
☐ 2 view lumbar, CPT 72100 (AP, LAT)
☐ Other _____ ☐ CPT _____

Medical X-ray Findings ☐ WNL
Positive for: ☐ Fracture/Dislocation
☐ Gross Osseous Pathology
☐ Pathology as noted
below:

Chiropractic X-Ray Findings Date taken ____/____/_____
Describe:

TREATMENT PLAN

Treatment Plan (MM/DD/YYYY)
From ____/____/_____
To ____/____/_____

No. of Visits Requested_____

Patient Home Care
☐ Stretching ☐ Exercise ☐ Hot/cold

Proposed Adjustive Techniques
Manual Technique(s): ☐ Diversified
☐ Gonstead ☐ Activator ☐ Other_____

Comments/Goal of Tx
Reduce pain _____ %
Improve ROM _____ %
Other:

Anticipated release date ____/____/_____

Complicating Factors *(Check any that apply and/or list)*

☐Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease
Other:

☐Anatomical deficit such as: asymmetrical facets, djd, spinal stenosis, spondylolisthesis, congenital or acquired joint anomaly, 3rd trimester pregnancy, >100 lbs. overweight
Other:

I declare that the above information is true and correct to the best of my knowledge.

Signature _____Date_____

****Please feel free to submit any and all additional information not included on the Treatment Plan form that you feel is necessary to support the services you are requesting.****