3545 NW 58th, Suite 500, Oklahoma City, OK 73112
Phone: 1-800-543-6044 or 1-405-717-8879
FAX: 1-405-717-8935

CHIROPRACTIC TREATMENT REQUEST

This information is private and confidential.

Physician: ____________________ Date: ____________________

Mailing Address: ____________________ City, State, Zip: ____________________

Contact Person: ____________________ ____________________

Phone: ____________________ Fax # : ____________________

Patient: ____________________ DOB: ____________________

Member: ____________________ Member ID #: ____________________

Diagnosis & Summary of Care: ____________________

____

____

Original Short/Long Term Goals: ____________________

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New Goals: ____________________

____

____

TREATMENTS

Initial Evaluation Date: ____________________

Total # Treatments To Date This Calendar Year:________

Beginning Date for Additional Treatments: ______________ *(required)*

Total # Additional Treatments Being Requested: ________

Frequency of Treatments Being Requested: ____________

Ending Date for Additional Treatments: ______________ *(required)*

*******************************FOR HEALTHCHOICE USE ONLY (Do Not Write Below This Line)*******************************

Extension #1	Circle One	APPROVED	DENIED	Reviewer	Date
# of Treatments Approved			Start Date		Ending Date
Extension #2	Circle One	APPROVED	DENIED	Reviewer	Date
# of Treatments Approved			Start Date		Ending Date

COMMENTS: ____________________

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NOTE: These benefits are applicable only if the patient is eligible for the Employees Group Insurance program (HealthChoice), and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1-800-782-5218.
MEDICARE PATIENTS: If HealthChoice is supplement, all services requested must be approved by Medicare.

Rev. September, 2008