For Staff: Appt Date: ___/___/____ Code: 97140/97124/97112
Primary DX: Secondary DX:

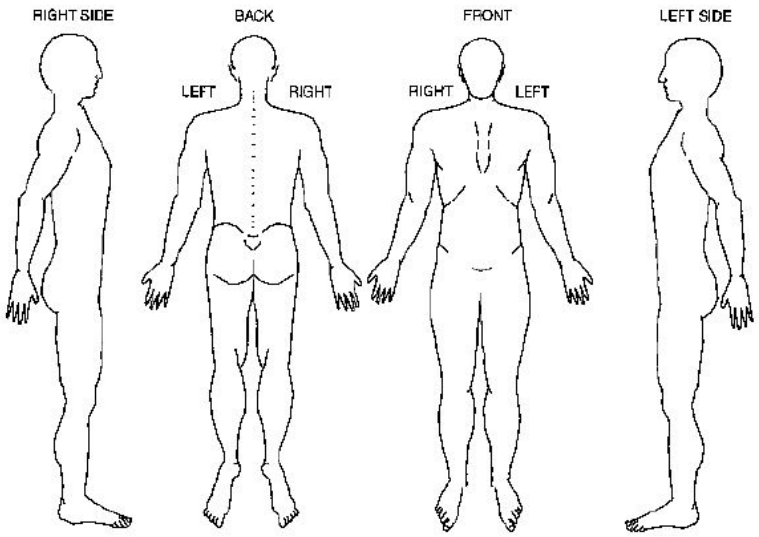
Parliament
CHIROPRACTIC

Premera BCBS Authorization Questionnaire

Patient Name: _____ Date: _____/_____/_____

In order to utilize your Massage/Manual Therapy Benefits, your insurance company wants us to collect clinical information from you to determine whether the procedure is Medically Necessary.

1. Please Circle the Areas that you want Treated:



2. Is this a new condition/ episode? □ Yes □ No Date of Onset: ____/____/_____
3. Have you been treated for this condition within the last 6 months? □ Yes □ No
4. In the past 3 years, how many times has this condition occurred? □ 1 □ 2 □ 3 □ ≥4
5. Is this for Post-Surgical Care? □Yes □ No
    a. If yes, please list the surgery: _____ Date: __/___/____
6. Skip to Question 7 if this is a new condition.
    a. Has there been any unusual activity that adversely effected your progress with this condition (e.g. "over did" something, suffered an additional injury, unable to complete home program, etc.)? □ Yes □ No
    b. If yes, please explain what happened: _____
7. Do you have radiating pain to or below your knee(s)? □ Yes □ No
8. Do you have radiating pain to or below your elbow(s)? □ Yes □ No

Please Initial: _____