AUTHORIZATION REQUEST FOR ADDITIONAL CHIROPRACTIC TREATMENT

PLEASE TYPE OR PRINT AND PROVIDE ALL OF THE INFORMATION REQUESTED

Claim Number

REQUEST FOR ADDITIONAL CHIROPRACTIC TREATMENT

Name of Injured Employee | SSN # | Date of Injury

Name of Employer | Name of Treating Chiropractor

Date of Last Treatment | Number of Treatments Since Injured's First Visit

DESCRIBE THE PRESENT CONDITION OF THE INJURED EMPLOYEE (Include Your Objective Findings, Symptoms, and Patient Complaints)

DEFINE AND GIVE THE NUMBER OF ADDITIONAL TREATMENTS FOR WHICH AUTHORIZATION IS REQUESTED:

Give the Date By Which the Treatment Will Be Completed If Authorization is Granted:

Is the Injured Employee Capable of Working Now? [ ] YES [ ] NO

If "**NO**" Estimate the Date By Which The Employee Will Be Able To Return To Work:

Date | Signature and Address of Treating Chiropractic Physician | Telephone Number

D.C.

FOR INSURER'S ACTION

[ ] AUTHORIZATION IS GRANTED FOR ADDITIONAL CHIROPRACTIC TREATMENTS.

[ ] Authorization for Additional Chiropractic Treatment is **Denied**

[ ] Other Action:

Date | Signature | Title