

**KINGSTON TRUST FUND**

Utilization Management by Hughes and Associates  
196 Charmant Drive Ste 3, Ridgeland, MS 39157  
Phone: (844) 583-3863  
Fax: (601) 981-1778

**THERAPEUTIC MASSAGE**

**(Acupuncture)**

Patient Name: \_\_\_\_\_  
Insured ID#: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

Treating Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**PREVIOUS TREATMENT**

First Office Visit: \_\_\_\_\_ Response to Care: \_\_\_\_\_  
Total Number of Visits: \_\_\_\_\_  
Number of visits since first of the year: \_\_\_\_\_

DIAGNOSIS	ICD 10 Code	AUTHORIZATION REQUEST
1. _____	_____	Start Date: _____
2. _____	_____	Frequency: _____
3. _____	_____	Duration: _____

**EVALUATION FINDINGS:** Date of Onset: \_\_\_\_\_

Chief Complaints/Current Complaints: \_\_\_\_\_  
\_\_\_\_\_

Mechanism of Injury/Onset: \_\_\_\_\_

Past History: \_\_\_\_\_  
\_\_\_\_\_

ROM: \_\_\_\_\_  
\_\_\_\_\_

Assessment: \_\_\_\_\_  
\_\_\_\_\_

Radiographic Findings: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_  
\_\_\_\_\_

Current Treatment Goals/Outcome: \_\_\_\_\_  
\_\_\_\_\_

Estimated Date of Release: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_