KINGSTON TRUST FUND

Utilization Management by Hughes and Associates
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THERAPEUTIC MASSAGE

(Chiropractic)

Patient Name: _____	**Treating D.C.:** _____
Insured ID#: _____	**Address:** _____
Address: _____	**City:** _____
City/State/Zip: _____	**State/Zip:** _____
Phone: _____	**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: _____

_____

Ortho/Neuro/Vascular: _____

_____

Chiropractic/Palpatory Assessment: _____

_____

Radiographic Findings: _____

Treatment Plan: _____

_____

Current Treatment Goals/Outcome: _____

_____

Estimated Date of Release: _____

Doctor's Signature: _____ **Date:** _____