



17761

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●) V:PalladianDCTreatment(2.1)20150901

Section A. Provider information

Form for Section A: Provider information including fields for First Name, Last Name, Facility Name, Service Add., NPI, State, and Zip.

Section B. Patient information

Form for Section B: Patient information including fields for First Name, Last Name, Health Plan, Member ID, Date of Birth, Onset, Last Visit, and Requested Start.

Section C. Primary region of complaint (select only 1 region) and primary diagnosis (ICD-10 number or text description)

Form for Section C: Primary region of complaint and primary diagnosis. Includes radio button options for Cervical, C/S+radiculopathy, Thoracic, Lumbosacral, L/S+radiculopathy, Shoulder, Elbow, Wrist, Hand, Hip, Knee, Ankle, Foot, Headache, and Other. Includes ICD-10 field and Authorization Request for: Treatment only, X-ray only, Both.

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology) and X-rays

Form for Section D: Red flags and X-rays. Includes questions about red flags, contraindications, X-rays, and rule out conditions.

Section E. Neurologic involvement associated with any spine condition

Form for Section E: Neurologic involvement. Includes questions about symptoms/signs of neurologic involvement and overall severity.

Section F. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary spine condition? Please choose one box for each of these columns.

Form for Section F: Evaluation. Table with columns: Symptoms, Physical function, Overall health, Prognosis. Rows: Very mild, Mild, Moderate, Severe, Very severe.

Section G. Management plan (i.e. how you plan on managing this patient's complaint)

Form for Section G: Management plan. Table with rows: Education about, Home/self-care, Supervised exercise, Modalities, Manual therapy. Columns: Diagnosis, Prognosis, Remaining active, Specific exercises, Other, None.

Form for Section G: Management plan. Number of DC visits used since last DC Treatment Form was submitted: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, Other.

Phone and Fax fields.

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Provider signature and Date fields.



Note: By completing and signing this form, the provider indicates that they: 1. provided all services, and 2. are a participating provider, and 3. provided all services in a credentialed practice.