

F. Treatment plan request:

1. Total number and Level of treatments requested. The Frequency of requested visits and the level of treatment should decrease in frequency and intensity: If greater than 50% of these treatments are 98941, provide clear rationale for treatment at that level and submit all daily notes and clinical findings.

Week	Number of visits	98940	98941	98942
1				
2				
3				
4				
Total				

3. Radiographic Imaging Requested: Yes No

If yes, describe the views (CPT codes) requested: _____

Describe rationale for radiographic films: _____

4. Goals of Chiropractic Care: _____

5. Plan to achieve Goals: _____

6. Patient "self care" program. Describe home exercise prescribed and patient education that will assist the patient in the self management of their complaint.

To the best of my knowledge the information provided above is true and accurate. In my professional opinion and best clinical judgment, this request for chiropractic treatment describes a safe and effective treatment plan that will serve to benefit the patient.

Provider Signature _____ Date _____