



Chiropractic Services Treatment Plan
(request for continued treatment beyond initial treatment plan)

I. TO: Piedmont Community Health Plan (PCHP) FAX No: 434-947-4465
FROM: _____ — Chiropractic Services
PATIENT'S NAME: _____
SSN# ON INSURANCE CARD: _____
PCP: _____
EMPLOYER: _____
ORIGINAL AUTHORIZATON NUMBER: _____
CHIROPRACTIC SERVICES FAX No.: _____

II. CHIROPRACTIC THERAPY TREATMENT PLAN
(Therapy limited to 4-6 weeks treatment plan, no more than 3 visits per week without a call to PCHP)

1. Date of last service: _____
2. No. of visits utilized of last approved tx plan: _____
3. Progress / Improvement at completion of last tx plan: _____

4. Current diagnosis / complaints: _____

5. Plan of tx requested, including duration and modalities: _____ X per _____ X _____ week/weeks
6. Modalities: _____

7. Goals upon completion of tx plan: _____

III. Approved: _____ Comments: _____
Signed: _____ Date: _____

NOTE: APPROVAL OF THIS TREATMENT PLAN DOES NOT APPROVE PAYMENT BEYOND BENEFIT DESIGN.