CHIROPRACTIC PREAUTHORIZATION FORM

Manitoba Families
Provincial Services
Health Services Programs
100-114 Garry St.
Winnipeg, MB R3C 4V4

Phone: (204) 948-3666
Fax: (204) 945-3930

1. IDENTIFYING INFORMATION

CHIROPRACTOR	PATIENT
Name:	Last name:
Address:	First name:
	Address:
Phone number:	Date of birth:
Fax number:	Certificate number:
Signature:	Signature:

2. DIAGNOSIS AND EXAMINATION FINDINGS

Diagnosis of present condition

☐ Subluxation Complex ☐ Fixation ☐ Other (please explain) _____

Location of diagnosis:

Subjective complaints:

Objective findings to substantiate diagnosis (eg orthopedic tests, ROM findings):

Complicating/aggravating factors:

3. TREATMENT PLAN

Proposed # of adjustments : Start date: End date:

Date 1st MHSC visit utilized this year: Was this for same diagnosis as above? ☐ YES ☐ NO

Date 7th MHSC visit utilized this year: Was this for same diagnosis as above? ☐ YES ☐ NO

Is this request an extension for a new condition? ☐ YES ☐ NO

Remarks:

4. AUTHORIZATION (OFFICE USE ONLY)

Date received:	Certificate expiry:	Approved as requested: ☐
Panel Review Date:	Din#:	Approved with modifications: ☐
Authorized by:		More information required: ☐

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