

Acupuncture Precertification Form

QualCare, Inc.
30 Knightsbridge Road
Piscataway, NJ 08854-3754

Patient's Name:	ID Number:	Group:
Date of Birth:	Age:	Other Medical Insurance: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, Name:	Policy Number:	
If MVA/Other: Date of Accident:	Ins. Name:	Phone: Policy#:
Treatment Start Date:		Number of Visits Requested :
Primary symptoms:		
Duration:	Frequency:	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
Quality: <input type="checkbox"/> Ache <input type="checkbox"/> Burning <input type="checkbox"/> Numbness <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Spasm		
Pain Level (0-10)	Best Worst	Exacerbated by:
Onset Date:	Diagnosis due to:	<input type="checkbox"/> MVA <input type="checkbox"/> WC <input type="checkbox"/> Other N/A <input type="checkbox"/>

Condition/Diagnosis		
Post Operative Nausea/Vomiting		
Post Chemotherapy Nausea/Vomiting		
Post Operative Pain		
Musculoskeletal Pain		
Pain caused by local or metastatic Malignancy		
Headache		
As part or all of the anesthesia administered in connection with surgical procedures		
Other		

Additional Information/Special Testing/Deficits/Physical Exam Results:

Diagnosis: (List by ICD 9 Code)

1.	2.	3.	4.
Goals	Short Term		Long Term
1.		1.	
2.		2.	
3.		3.	
4.		4.	

Provider: _____	Tax ID Number: _____
Phone Number: _____	Contact Name/ _____
	Fax Number: _____

Pre-Certification Department Fax Number: 732-562-1023

PPO 800-992-6613 (Phone) HMO Network 800-254-0130 (phone)