

MEDICARE AFFIDAVIT:

Patient's statement "documenting" medical necessity of care, a sworn statement by "Federal" Documentation Format

TO THE BEST OF MY KNOWLEDGE THIS FORM MEETS THE REQUIREMENTS OF THE CARRIER

Peer Qualifications: Western States Chiropractic College, Doctor of Chiropractic, Licensed in the state of WA
Continuing Education: Current per WA state requirement

Patient Exacerbation Document

Date: _____
Name: _____ Address _____
City: _____ State _____ Zip _____ Phone _____

Date of Exacerbation _____ (Any event that the patient has experienced that has affected the patient's condition bringing pain or discomfort, gheat or small, in relation to the pre-disposed chronbic condition.)

Patient's Statement

Chiropractic Care gives me relief from symptoms and results in improvement of my condition:
YES _____ NO _____

Diagnosis: Fee Slip attached

Treatment Plan:

Office Visits _____
Frequency _____
End of Care/Review _____

Doctor's Name Catherine Englehart, DC

NPI # 1477614931/1235316522

G8871015

Medicare # G8871016/

Doctor's Signature

Tax ID: 91-1896558

A temporary marked deterioration of the patient's condition due to an acute exacerbation of a predisposed problem. This exacerbation has been clearly documented in the patient's clinical record. There is good likelihood this care will improve the patient's physical and functional status. Both **Subluxation** and **Medical Necessity of Care** have been documented. (Title SVIII Social Security Act)
It is the intent of this office to follow all Medicare Guidelines to the best of our ability.