



**Important note:** The treatment plan for chiropractic care **MUST** be prepared by the chiropractor and signed by the patient's M.D./D.O.

**1 MESSA Member/Patient Information**

MEMBER NAME	SUBSCRIBER ID NUMBER
<input type="text"/>	<input type="text"/>
PATIENT NAME	PATIENT DATE OF BIRTH (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>

**2 Treatment Plan**

DATE OF SERVICE	MEDICAL DIAGNOSIS (ICD-10-CODE)
<input type="text"/>	<input type="text"/>
TYPE AND FOCUS OF TREATMENT TO BE PROVIDED	
<input type="text"/>	
FREQUENCY OF TREATMENT	DURATION OF TREATMENT
<input type="text"/>	<input type="text"/>

**3 Chiropractor Information**

NAME OF CHIROPRACTOR	TAX ID NUMBER		
<input type="text"/>	<input type="text"/>		
ADDRESS	NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER		
<input type="text"/>	<input type="text"/>		
CITY	STATE	ZIP CODE	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**4 Primary Care Provider Information**

NAME OF M.D./D.O.	TAX ID NUMBER		
<input type="text"/>	<input type="text"/>		
ADDRESS	NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER		
<input type="text"/>	<input type="text"/>		
CITY	STATE	ZIP CODE	PHONE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_