Acupuncture for Chronic Low Back Pain: Medical Attestation

Patient Name_____ Birthdate_____ Patient ID#_____
(mm/dd/yyyy)

Health Plan_____ Subscriber Name_____ Subscriber ID#_____

We understand that you would like acupuncture treatment for your low back pain. Medicare benefits do cover the cost of acupuncture for *some types* of low back pain. Please answer the questions below to see if your Medicare benefit will cover acupuncture for your low back pain.

1. Have you had low back pain for 12 weeks (3 months) or longer? ☐ Yes ☐ No

2. Thinking about your low back pain; have any health care providers told you that any of the following are currently causing your low back pain?

No	Yes	
☐	☐	Non-specific or general low back pain or sciatica
☐	☐	An infection in the bone such as tuberculosis or osteomyelitis
☐	☐	Cancer
☐	☐	A current pregnancy
☐	☐	Body inflammation from conditions like rheumatoid arthritis, psoriatic arthritis, lupus, Crohn's disease, ankylosing spondylitis, Ulcerative colitis
☐	☐	A condition in the kidney, ovaries, intestine, prostate, bladder, or uterus

3. Have you had:

No	Yes	
☐	☐	Surgery to your low back, hip, or pelvis

4. What is the name and contact information of your primary medical provider? (*This is the person who knows your medical history and would help you if your back pain did not improve or got worse*.)

Medical Provider Name_____ Phone (required)_____

Address_____

5. I attest that these answers are accurate. I understand that my answers will help determine eligibility for coverage. The Acupuncture provider will also provide information to confirm coverage.

Attested by_____ Date_____
signature of patient

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6. As the Acupuncture provider for this Medicare Advantage member:

☐ **I attest that the information above has been written and submitted by the patient and I have reviewed the answers with the patient and the answers:**

☐ **Meet Medicare eligibility requirements** ☐ **Do NOT meet Medicare eligibility requirements**

Attested by (signature of Licensed provider)_____ Date_____

Provider (TIN Owner) Name_____ Facility/Clinic Name_____

Facility/Clinic Address_____

Acupuncture provider must retain this form in the patient medical record. This document may be requested by ASH or its clients to audit compliance with coverage policy.