



For Customer Service, call 833-663-8705.

Please verify the member's benefits prior to submission of review request.

Patient Information					
First Name		Middle Initial		Last Name	
Date of Birth	Contract Number (include prefix)			Group Number	Precertification Request Date
Physician Resources					
Physician First Name		Middle Initial		Last Name	
National Provider Identifier (NPI)					
Address					
City			State	Zip	
Office Contact			Office Telephone	Fax Number	
Primary ICD-9* Code (do not use V code)	Onset Date	Secondary ICD-9* Code (do not use V code)		Onset Date	
Diagnosis Information					
Has patient had previous chiropractic care for this condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date:	
List any conditions or complicating factors that impact care.					
List all dates of service for the current calendar year.					
1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.
13.	14.	15.	16.	17.	18.
19.	20.	21.	22.	23.	24.
Certification Information					
Initial Certification <input type="checkbox"/> Copy of initial evaluation <input type="checkbox"/> Last 5 treatment notes <input type="checkbox"/> Current reassessment with objective findings, updated goals, progress towards goals, current treatment plan, including frequency/duration - performed at 12th visit <input type="checkbox"/> Number of visits requested for this certification _____ <input type="checkbox"/> Projected end date of care _____ <input type="checkbox"/> Please justify the need for continuation of care.			Additional Certification <input type="checkbox"/> Treatment notes from previously certified visits. Documentation should include objective findings/functional limitations and any additional information from last certified visit to support medical necessity for additional visits. <input type="checkbox"/> Number of visits requested for this certification _____ <input type="checkbox"/> Projected end date of care _____ <input type="checkbox"/> Please document changes in treatment plan and/or the patient's condition to warrant the course of treatment.		

*International Classification of Diseases – Ninth Revision (ICD-9)

Submission Instructions
Please fax this form with all applicable documentation to 833-719-1601 . A review cannot be completed without the required information.