Chiropractic Prior Authorization Form

Recipient/Patient: _____ MAID #: _____ Date of Birth: ____/____/____

Complaint(s): _____ ⊖New Episode ⊖Continuing Care

Date of Onset: ____/____/____ Mechanism of Onset: _____

Other Treatment & Medications received: _____

Complications: _____

Patient Section: On the blank line in the left hand column, write in each area of complaint (example: neck, low back), then...

For Continuing Care after 12 visits, please complete all. For new episode after 12 visits, please mark Pain Scale and Remarks only.

_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____
_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____
_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____
_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____
_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____
_____	☐ Improved	☐ Same	☐ Worse	Pain Level (0-10) = ____	Remarks: _____

Provider Section: Date of 1st Exam:: ____/____/____ (if continuing care requested) Date of this exam: ____/____/____

Cervical Range of Motion:

Initial Exam	*Degree*	*Sharp Pn*	*Dull Pn*	*Notes*	*Current Exam*	*Degree*	*Sharp Pn*	*Dull Pain*	*Notes*
Flexion	/50	L M R	L M R		*Flexion*	/50	L M R	L M R	
Extension	/70	L M R	L M R		*Extension*	/70	L M R	L M R	
Rt Rotation	/85	L M R	L M R		*Rt Rotation*	/85	L M R	L M R	
Lt Rotation	/85	L M R	L M R		*Lt Rotation*	/85	L M R	L M R	
Rt Side Bend	/45	L M R	L M R		*Rt Side Bend*	/45	L M R	L M R	
Lt Side Bend	/45	L M R	L M R		*Lt Side Bend*	/45	L M R	L M R	

Lumbar Range of Motion:

Initial Exam	*Degree*	*Sharp Pn*	*Dull Pn*	*Notes*	*Current Exam*	*Degree*	*Sharp Pn*	*Dull Pn*	*Notes*
Flexion	/90	L M R	L M R		*Flexion*	/90	L M R	L M R	
Extension	/30	L M R	L M R		*Extension*	/30	L M R	L M R	
Rt Side Bend	/35	L M R	L M R		*Rt Side Bend*	/35	L M R	L M R	
Lt Side Bend	/35	L M R	L M R		*Lt Side Bend*	/35	L M R	L M R	

Orthopedic and Other Tests:

Initial Exam	*Sharp Pn*	*Dull Pn*	*Location of Pain*	*Current Exam*	*Sharp Pn*	*Dull Pain*	*Location of Pain*

Treatment Modalities and Procedures with Goals: (# means number of each CPT requested, Goals means specific goal for that CPT code)

CPT Code	*#*	*Goals*	*CPT Code*	*#*	*Goals*

Imaging Findings (Xray, MRI, etc): _____

Additional Comments: _____

Diagnosis Codes: _____

Additional Visits and Weeks Requested: *Continuing:* _____*visits/*_____*weeks* **OR** *New:* _____*visits/*_____*weeks*

Provider: _____ *Provider #:* _____ *Date:* ____/____/____

Provider Telephone: _____ *Fax:* _____ *Signed:* _____

For HRC Office Use Only: Completed Plan Approved? Yes No PA Number:

Mail to: **Healthcare Review Corporation**
9200 Shelbyville Rd., Suite 800
Louisville KY 40222-8504

Or FAX to : 502-429-5233

(Please attach any pertinent additional documentation)