



CERTIFICATION FOR CHIROPRACTIC VISITS FORM

For Customer Service call 1-205-220-7202 or call toll-free 1-800-845-6039

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

Patient Information

Form fields for Patient Information: First Name, Middle Initial, Last Name, Date of Birth, Contract Number, Group Number, Precertification Request Date

Physician Resources

Form fields for 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-10* Code, Onset Date, Secondary ICD-10* Code, Onset Date

Diagnosis Information

Form fields for Diagnosis Information: Has patient had previous chiropractic care for this condition? (Yes/No), If Yes: Date, List any conditions or complicating factors that impact care

List all dates of service for the current calendar year.

Table with 6 columns for listing dates of service from 1 to 24.

Certification Information

Form fields for Certification Information: Initial Certification (Copy of Initial Evaluation, Last 5 Treatment Notes, Current Reassessment, Number of Visits Requested, Projected End Date, Justify need for continuation), Additional Certification (Treatment Notes, Number of Visits Requested, Projected End Date, Document changes in treatment plan)

*International Classification of Diseases – Tenth Revision (ICD-10)

Submission Instructions

Please fax this form with all applicable information documented. A review can not be completed without the required information. Fax to: 1-205-402-9292