uchealth

PSD CHIROPRACTIC/ACUPUNCTURE AUTHORIZATION FORM

Fax #: 970-224-0128

Patient Name_____DOB:_____
(last, first)

Member ID Number: _____

Diagnosis:_____ ICD-10 code:_____

Services Requested:_____ CPT/HCPC code:_____

Pre-Authorization to access medical necessity should include a written plan of care with the following:

Acupuncture requests

1. Diagnosis along with the date of onset or exacerbation of the diagnosis/disorder
2. A reasonable estimate of when the goals will be reached;
3. Long-term and short term goals that are specific, quantitative and objective;
4. Acupuncture evaluation;
5. The frequency and duration of treatment; and
6. The acupuncture protocol to be used in treatment.

Chiropractic requests

1. Diagnosis along with the date of onset or exacerbation of the diagnosis/disorder
2. A reasonable estimate of when the goals will be reached;
3. Long-term and short term goals that are specific, quantitative and objective;
4. The frequency and duration of treatment

Provider Signature: _____ Date: _____

Contact person: _____ Contact phone #: _____

Contact person Fax #: _____

FOR ADMINISTRATION DOCUMENTATION ONLY:

APPROVED:_____ DENIED:_____ PENDED:_____ AUTH NUMBER: _____

COMMENTS: