



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:

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