WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____ **FAX 1-844-633-8431 CHIROPRACTIC**

REGISTRATION ON Atrezzo IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON HTTPS://PROVIDERPORTAL.KEPRO.COM

Atrezzo Requesting/Submitting Organization _____

Address, City, State, Zip _____

Atrezzo Requesting/Submitting Organization NPI_____ Please list exactly as registered

Person Submitting Request _____ **Phone** _____ **Fax** _____ **Email**_____

Referring/Ordering Provider (Per policy the Referring/Ordering Provider must be actively enrolled with WVCHIP)

Name Do not write "See Above"	**NPI Number**	
Contact Information	**Phone**	**Fax:**

Place of Service/Servicing Provider (Per policy the Place of Service/Servicing Provider must be actively enrolled with WVCHIP)

Name Do not write "See Above"	**NPI Number**
Address, **City, State, Zip**	

Member WVCHIP Number _____ **DOB**_____

Member First Name _____ **Last Name** _____

Authorization Type:

☐ **Prior Authorization**

☐ **Retrospective WVCHIP Eligibility**

☐ **Retrospective Request, if applicable list the appropriate reason:**

List Other Retro Reason:

Type of Admission/Procedure: ☐ **Emergency/Medically Urgent** ☐ **Non-Urgent** **Place of Service: Office**

List ICD Diagnosis Code(s):

Primary ICD DX: _____

Symptoms: _____

Other DX:

CPT/Service Code(s) Requested:

_____|_____|_____ Are the phys

START DATE_____

If No, please list why:

_____

OTHER CHIROPRACTIC SERVICE CODES REQUESTED:

Service Code	Description	POS Office	POS Clinic	Start Date	Number of Units
72010	X-Ray Exam of Spine				
72020	X-Ray Exam of Spine				
72040	X-Ray Exam of Neck Spine				
72050	X-Ray Exam of Neck Spine				
72052	X-Ray Exam of Neck Spine				
72069	X-Ray Exam of Trunk Spine				
72070	X-Ray Exam of Thoracic Spine				
72072	X-Ray Exam of Thoracic Spine				
72074	X-Ray Exam of Thoracic Spine				
72080	X-Ray Exam of Trunk Spine				
72090	X-Ray Exam of Trunk Spine				
72100	X-Ray Exam of Lower Spine				
72110	X-Ray Exam of Lower Spine				
72114	X-Ray Exam of Lower Spine				
72120	X-Ray Exam of Lower Spine				
98940	Chiropractic Manipulation				
98941	Chiropractic Manipulation				
98942	Chiropractic Manipulation				

EVALUATION SUBJECTIVE COMPLAINTS

Limited Range of Motion: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Numbness: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Other: ☐Yes ☐No
List _____
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Pain: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Tingling: ☐Yes ☐No
If Yes: ☐*Mild* ☐*Moderate* ☐*Severe*

Subluxations:
☐ Cervical ☐ Lumbar ☐ Thoracic ☐ Other
_____
Subluxation Notes:

Frequency of Visits: ☐Bi-Weekly ☐Monthly ☐Weekly ☐Other (Describe):

Explain Declining Frequency of Visits

History of Exacerbations

Objective Findings

Prognosis

Extenuating Circumstances

ACTIVITY MODIFICATIONS ☐Yes ☐No
If YES mark duration ☐0-3 Months ☐3-6 Months ☐6-9 Months ☐9-12 Months ☐12+ ***and list outcome, if NO list why:***

NSAIDS ☐Yes ☐No
If YES mark duration ☐0-3 Months ☐3-6 Months ☐6-9 Months ☐9-12 Months ☐12+ Months ***and list outcome, if NO list why:***