Chiropractic Treatment Pre-Authorization (PA) Request Form

BlueCross BlueShield Minnesota

Please submit your request using Availity.

Include this completed form and relevant clinical information. If unable to submit using Availity, fax completed form and clinical documentation to **651-662-7816.**

Patient Information

Member ID: _____ __________________________ Group Number: ___________________

Member Name: ____________________________________ Date of Birth: ____________________

Member Address: ____

Member City/State/Zip: ____

Member Phone: _________________________

Primary Diagnosis Code: _________________ Diagnosis Description: _________________________

Secondary Diagnosis Code(s): ____________ Diagnosis Description: _________________________

Request Type: ☐ Initial ☐ Ongoing Medicare or another insurance primary: ☐ YES ☐ NO

Has the patient seen another Chiropractor in this calendar year? ☐ YES ☐ NO

Number of Chiropractor visits from January 1 of current year to start date of this request: _________

Servicing Provider Information

Contact person: ____ Phone: ______________________

Provider Name: ____

Provider ID / NPI Number: ____________________________

Provider Address: ____

City/State/Zip: ____

Provider Phone: _________________________ Provider Fax: _________________________

Is the Servicing Provider participating with the local Blue Plan? ☐ YES ☐ NO

Chief Complaint

Chief Complaint:

Initial start of service: ______________________

Date of onset / exacerbation for this condition: ______________________

Clinical Presentation: ☐ Acute ☐ Sub-Acute ☐ Chronic ☐ Recurrent ☐ Spinal Stenosis

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History & Physical Exam

Date of Initial Exam / Re-Exam: ______________________

Patient's rating per the Pain Severity Scale **Initial:** _____ / 10 **Current:** _____ / 10

Patient history related to this diagnosis:

Is there a functional impairment related to this diagnosis? ☐ YES ☐ NO

If yes, please define: ☐ Mild ☐ Moderate ☐ Severe

Provide examples of progressive improvement with functional impairments:

Other significant history / medical / medications / treatment information:

Current Clinical Findings

Level of Spasms:

Cervical:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe
Thoracic:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe
Lumbar:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe

Level of ROM functional limitation:

Cervical:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe
Thoracic:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe
Lumbar:	☐ Normal	☐ Mild	☐ Moderate	☐ Severe

If limitations exist, they are: ☐ With Pain ☐ Without Pain

Neurological findings: ☐ Normal ☐ Other: ____

Unilateral / Bilateral Weakness? ☐ YES ☐ NO

Normal sensory / reflex / motor-strength findings? ☐ YES ☐ NO

Explain: ____

Orthopedic Findings: ☐ Normal ☐ Localized ☐ Radiating ☐ Other: ___________________

Orthopedic Tests Performed: ____

Other Significant Findings: ____

Treatment Plans & Services Requested	**Treatment may be requested for 30 to 60 days** _______ Visits per week for ______ weeks from ____________________ to ____________________ _______ Visits per week for ______ weeks from ____________________ to ____________________ _______ Visits per week for ______ weeks from ____________________ to ____________________ Total Number of Chiropractic Treatments Requested: _________ Other therapy being provided to support diagnosis: ____ Were X-Rays indicate for this diagnosis? ☐ NO ☐ YES – Views: ____________________________ Specific / Measurable Short and Long-Term Treatment Goals: Does the patient agree with the goals? ☐ NO ☐ YES Does the patient understand the Home Exercise Program? ☐ NO ☐ YES Document prescribed Active Care and provide examples of patient compliance and commitment:
Submitted Documents	**Please submit and ☒ Check the following documentation included with this request form:** ☐ Detailed History and Examination Findings ☐ Detailed Documentation of functional impairments with ADL's and IADL's ☐ Detailed Documentation of Progressive Improvements ☐ Details of Specific and Measurable Short and Long-term Goals ☐ Details of the Patients Home Exercise program ☐ Documentation of Patient Compliance / Commitment to the Home Exercise Program

Chiropractic Treatment Request Instructions

When submitting an *initial request*,
please include documentation for <u>ALL</u> of the following elements:

☐ Standardized objective assessments of the patient's impairments, functional limitations, and disabilities

☐ Therapy diagnosis and prognosis

☐ Patient-specific objectively measurable goals of treatment and expected outcomes

- Activity/Performance
- Specific functional outcomes
- Objective measurements of the activity/performance
- Time frame for achieving goals

☐ A patient-specific plan of treatment

☐ A patient-specific discharge plan

☐ An established Home Exercise Program

When submitting a request for *ongoing therapy*,
please include documentation for <u>ALL</u> of the following elements:

☐ A copy of the Initial Evaluation for current plan of care

☐ A summary assessment of the patient's impairments, functional limitations, and disabilities including:

- The reduction in intensity and frequency of symptoms
- Improvements in function and reductions in limitations
- Prognosis for further clinical or functional improvement

☐ A summary of progression towards the goals of treatment plan and independence in self-management

☐ Provider documentation of compliance by member / caregiver regarding their home exercise program and continued teaching of the home exercise program