



# WVCHIP PRIOR AUTHORIZATION FORM

Today's Date \_\_\_\_\_

**FAX 1-844-633-8431 CHIROPRACTIC**

REGISTRATION ON ATTREZO IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.  
DETERMINATIONS ARE AVAILABLE ON <https://portal.kepro.com/>

ATTREZO Requesting/Submitting Organization \_\_\_\_\_ Please list exactly as registered on ATTREZO  
Address, City, State, Zip \_\_\_\_\_

ATTREZO Requesting/Submitting Organization NPI \_\_\_\_\_ Please list exactly as registered on ATTREZO

Person Submitting Request \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

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

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>	
<b>Contact Information</b>	<b>Phone</b>	<b>Fax:</b>

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

<b>Name</b> Do not write "See Above"	<b>NPI Number</b>
<b>Address, City, State, Zip</b>	

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: \_\_\_\_\_

Patient Status:  Established  New Period of Request:  30 Days  60 Days  90 Days

**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: