

An Independent Licensee of the Blue Cross and Blue Shield Association

CERTIFICATION FOR CHIROPRACTIC VISITS FORM

For Customer Service call 1-205-220-7202 or call toll-free 1-800-845-6039

Please verify the member's benefits prior to submission of review request.

| | | | | | 01 00 | 11 toll 1100 1 000 | 040 000 | , | |
|---|----------------------------------|---|-------------------|--|--|--------------------|--------------|---------------------------|--|
| Patient Information | | | | | | | | | |
| First Name | | | Middle Initial | | Last Name | | | | |
| Date of Birth | Contract Number (include prefix) | | | | Group Number | | | ertification uest Date | |
| Physician Resources | | | | | | | | | |
| Physician First Name | | | Middle Initial | | Last Name | | | | |
| National Provider Identifier (NPI) | | | | | | | | | |
| Address | | | | | | | | | |
| City | | | | | State | | Zip | | |
| Office Contact | | | | | Office Telephone | | | Fax Number | |
| Primary ICD-10* Code | Onse Date | t | | Second | dary ICD-10* Code | | Onse Date | | |
| Diagnosis Information | | | | | | | | | |
| Has patient had previous chiropractic care for this condition? | | | | | | | | | |
| List any conditions or complicating factors that impact care | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| List all dates of servi | ce for the current ca | lendar year. | | | | | | | |
| 1. | 2. | 3. | | 4. | | 5. | | 6. | |
| 7. | 8. | 9. | | 10. | | 11. | | 12. | |
| 13. | 14. | 15. | | 16. | | 17. | | 18. | |
| 19. | 20. | 21. | | 22. | | 23. | | 24. | |
| Certification Information | tion | | | | | | | | |
| Initial Certification | | | | Additional Certification | | | | | |
| Copy of Initial Evaluation | | | | Treatment Notes from previously certified visits. Documentation should include | | | | | |
| Last 5 Treatment Notes | | | | | objective findings/functional limitations and any additional information from last | | | | |
| Current Reassessment with objective findings, updated goals, progress towards | | | | certified visit to support medical necessity for additional visits. | | | | | |
| goals, current treatment plan, including frequency/duration - performed at 12th visit | | | | Number of Visits Requested for this Certification | | | | | |
| Number of Visits Requested for this Certification | | | | Projected End Date of Care | | | | | |
| Projected End Date of Care | | | | Please document changes in treatment plan and/or the patient's | | | | | |
| Please justify the need | CO | condition to warrant the course of treatment. | | | | | | | |
| *International Classification of Diseases – Tenth Revision (ICD-10) | | | | | | | | | |

*International Classification of Diseases — Tenth Revision (ICD-10)

Submission Instructions

Please fax this form with all applicable information documented.

A review can not be completed without the required information.

Fax to: 1-205-402-9292