Prior Authorization Form
Chiropractic Request

Phone: 1-800-521-6622 | Fax: 1-866-755-9949

AmeriHealth Caritas™
Pennsylvania

Contact name:

Phone number: Fax number:

Member information:	
Member name:	Member ID number:
Date of birth:	Member's phone number:
Authorization number, if applicable:	
Primary insurance? ☐ Yes ☐ No	Name of carrier:
Primary insurer member ID:	Primary authorization number:

Provider information:	
Physician name:	Physician NPI:
Physician phone number:	Physician fax number:

Codes

ICD diagnosis code	CPT code	Start date	Frequency (number of times per week)	Duration (number of weeks)

Chiropractic evaluation and treatment request		
Chief complaint:		Type of pain: ☐ Acute ☐ Chronic
		Type of request: ☐ Initial ☐ Ongoing
		Percentage of improvement since last request:
Loss of strength (1–5):	Pain rating (0–10):	Date symptoms/recurrence began:
Related surgery:		Examination findings:
ROM (area and degrees):		Neuro. exam:
Impression of recent radiology studies:		
Provide detailed list of ADL limitations: Mild (variable limits) Moderate (consistent limits) Severe (unable to complete)		
Treatment plan: Spinal manipulation: Exercises for strength/ROM/endurance: Engaged in home exercises? ☐ Yes ☐ No		
Goals:		Prognosis:

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED.
ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.