

Certification for Chiropractic Visits



BlueCross BlueShield
of Alabama

Blue Cross and Blue Shield of Alabama contact information:
 Faxpress: (205) 402-9292 Phone: (205) 220-7202

Please fax this form with all applicable information documented. A review can NOT be completed without the required information.

Precertification Request Date _____

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

1) Patient Name	2) Patient date of birth
3) Patient Contract Number (include prefix)	4) Group Number

Please print legibly

5) Provider Name	6) Provider Number
7) Provider Address	
8) Office Contact Person	
9) Office Telephone Number	10) Office Fax Number
11) Primary ICD 9 Code (do not use V Code) Onset Date	12) Secondary ICD 9 Code (do not use V code) Onset Date

13) Has patient had previous chiropractic care for this condition Y ___ N ___ If yes: Date _____

14) List any conditions or complicating factors that impact care _____

List all dates of service for the current calendar year:

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.
13.	14.	15.	16.	17.	18.

Initial Certification

_____ Copy of Initial Evaluation
 _____ Last 5 Treatment Notes
 _____ Current Reassessment with objective findings, updated goals, progress towards goals, current treatment plan, including frequency/duration - **performed at 12th visit**
 Number Visits Requested for this Certification _____
 Projected End Date of Care _____
 _____ **Please justify the need for continuation of care**

Additional Certification

_____ Treatment Notes from previously certified visits. Documentation should include objective findings/functional limitations and any additional information from last certified visit to support medical necessity for additional visits
 Number Visits Requested for this Certification _____
 Projected End Date of Care _____
 _____ **Please document changes in treatment plan and/or the patient's condition to warrant the course of treatment**