

WVCHIP PRIOR AUTHORIZATION FORM

Today's Date _____

FAX 1-844-633-8431 CHIROPRACTIC

REGISTRATION ON Atrezzo IS REQUIRED TO SUBMIT PRIOR AUTHORIZATION REQUESTS WHETHER BY FAX OR ELECTRONICALLY.
DETERMINATIONS ARE AVAILABLE ON [HTTPS://ATREZZO.ACENTRA.COM](https://atrezzo.acentra.com)

Atrezzo Requesting/Submitting Organization _____

Address, City, State, Zip _____

Atrezzo Requesting/Submitting Organization NPI _____ Please list exactly as registered

Person Submitting Request _____ Phone _____ Fax _____ Email _____

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

Name Do not write "See Above"	NPI Number	
Contact Information	Phone	Fax:

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

Name Do not write "See Above"	NPI Number	
Address, City, State, Zip		

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: _____

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: