VSHP Volunteer State Health Plan
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BlueCare®
TennCare*Select*
a state of Tennessee program

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☐ Public ☐ Internal (**Volunteer State Health Plan Use Only**) ☐ Confidential ☐ Highly Confidential

# Chiropractic Treatment Request Form

Request Form

BlueCare/TennCare*Select*

**Fax Number: 1-800-292-5311**

| **BlueCare** ☐ | **TennCare*Select*** ☐ |
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## Member Information

**Member Name:** **Member ID Number:**

**Address:**

**Date of Birth:** **Member Phone Number:**

**Diagnosis: (*List all*)**

## Chiropractic Provider Information

***Ordering Provider*:** **Provider Number:**

**National Provider Identifier:** **Tennessee Medicaid Number:**

**Phone Number:** **Fax Number:**

**Contact Name:**

***Servicing Provider* (if different than above) :** **Provider Number:**

**National Provider Identifier:** **Tennessee Medicaid Number:**

**Phone Number:** **Fax Number:**

***Servicing Provider* (if different than above) :** **Provider Number:**

**National Provider Identifier:** **Tennessee Medicaid Number:**

**Phone Number:** **Fax Number:**

**Contact Name:**

***A copy of the MD's written order (or details of the verbal order) must be submitted with this fax request.**

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**Is this an "initial request" or a "continuation request"**

**If this is an *initial request*, the *entire form* should be completed (with the exception of continuation information at the bottom of the form).**

**If this is a *continuation request*, please list the necessary information regarding the additional services requested (CPT codes, number of visits and dates of service), then proceed to the section of the form designated for continuation information.**

**Per the TennCare Exclusion Rule: Chiropractors' services are excluded from coverage except as medically necessary for children under the age of 21.**

**Service Requested: (please list appropriate Chiropractic CPT code(s)):**

**Number of treatments:** **Frequency of treatments:**

**Dates of service: (from) to**

***Please be aware, there are certain modalities that are not covered services. For this reason, please *list* the planned modalities in the plan of care (see below).**

**The following modalities listed are not appropriate as part of patient care and are not covered: Iontophoresis, Phonophoresis, Mechanized Axial Spinal Distraction Therapy Devices, Surface EMGs, Spinal Manipulation under Anesthesia, and Massage Therapy (not performed immediately before or after a manipulation).**

**Please refer to VSHP's Medical Policy for a complete and up to date listing of non-covered modalities. (www.vshptn.com**

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## INITIAL VISITS

**For an *initial* Chiropractic Request, the following information must be given to make a determination of medical necessity:**

*If this is a continuation request, please disregard the following questions and proceed to the section for "additional visits."*

**Date of Chiropractic Evaluation:**

**Brief patient history:**

**Summary of findings on Chiropractor's physical examination:**

**Pain rating:** **Pain location:** **Pain description:**

**Date of onset of pain and/or other problems:**

**Prior interventions and treatments tried:**

**Any recent surgeries or procedures?** **If yes, please list:**

**Any recent diagnostic imaging performed?** **If yes, what type and findings:**
***NOTE: X-rays and other diagnostic services performed in the chiropractic office are not covered; x-rays should only be performed if ordered by the PCP, and in-network facilities should be utilized.***

**What is the patient's baseline status?**

**What are the patient's current functional abilities (or inabilities)?**

**What is the patient's current muscle strength?**

**What is the patient's current ROM?**

**Any circulation and/or sensation problems?** **If yes, describe:**

**Is the patient receiving any other therapies or treatments (i.e., PT)?** **If yes, list:**

**What are the *patient's goals* (or caregiver's goals) for this course of chiropractic treatment?**

**What are the *chiropractor's treatment goals* for this patient? (Please list goals that are specific and measurable):**

**What is included in the chiropractic plan of care?**
**Will a home exercise program and education on safety precautions be included in the patient's education?**
**If No, why not?**

**What is the *predicted* period of time the patient would need chiropractic treatments?**

## ADDITIONAL VISITS

**FOR A MEDICAL NECESSITY REVIEW FOR *ADDITIONAL* VISITS, THE FOLLOWING INFORMATION SHOULD BE PROVIDED:**

***If this is an initial request, please be sure the initial questions are answered correctly (above). The section below does not need to be addressed for initial requests.***

**How many treatment visits has the patient completed?** **What was the date of last visit?**

**Has the Home Exercise Program (HEP) been taught?** **Does patient/caregiver report compliance with the HEP?**

**Are there any barriers to learning the HEP (patient or caregiver)?** **If yes, please list:**

**What progress has been made in the patient's condition? (Please refer to previous chiropractic goals)**

**Why (*in your opinion*) does the patient need to continue to have chiropractic treatments, rather than continuing the home exercise program?**

**Do you predict more visits may be needed past what is being requested at this time?** **If yes, why?**

***Notification is not a confirmation of coverage or benefits. Benefits remain subject to all contract terms, benefit limitations, conditions, exclusions, and the patient's eligibility at the time services are rendered. This request may be subject to retrospective review based on Medical Policy.***

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