3545 N.W. 58th St., Ste. 600, Oklahoma City, OK 73112
Phone: 405-717-8879 or 800-543-6044, ext. 8879
Fax: 405-949-5459 or 405-949-5501

CHIROPRACTIC THERAPY REQUEST

This form must be completed and accompany all requests. Incomplete forms will not be reviewed.

Billing Provider: ______________________________ Date: ______________

Billing Address: ______________________________

TIN: ______________________________ Contact Person: ______________

Phone: ______________________________ Fax: ______________

Patient: ______________________________ DOB: ______________

Member: ______________________________ Member ID: ______________

Diagnosis Codes and Summary of Care:

____

____

Original Short/Long Term Goals:

____

____

____

New Goals:

____

____

____

Date of Initial Evaluation: ______________ Total # Additional Treatments Requested: ______________

Total # of Treatments to Date this Calendar Year: ______ Frequency of Treatments Requested: ______________

Beginning Date for Additional Treatments: ______________ Ending Date for Additional Treatments: ______________

Comments:

____

____

____

**** All information is required for review. Information provided is private and confidential. ****

NOTE: These benefits are applicable only if the patient is an eligible enrolled member of a HealthChoice plan. All benefits are subject to the deductible, coinsurance and policy provisions. Please verify benefits and eligibility by calling the medical claims administrator toll-free at 800-323-4314.

MEDICARE PATIENTS: If HealthChoice is the supplemental insurance carrier, authorization from HealthChoice is not required. Please contact Medicare.