**VERMONT MEDICAID CHIROPRACTIC SERVICE REQUEST FORM**

Patient Name: Medicaid ID Number: Date of birth:

Chiropractor Name: Medicaid Provider #:

Office Contact Person: Phone: Fax:

**Chiropractic services require prior authorization from the Department of Vermont Health Access for the following: (1) Beneficiaries under the age of 12, or (2) Beneficiaries age 12 and older who have exceeded 10 treatments for correction of subluxation in the calendar year. Chiropractic services for children age five and under require prior authorization and require documentation from the primary care providers demonstrating medical necessity of chiropractic treatment. HCAR 4.220**

[**https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf**](https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/4.220-chiropractic-services-adopted-rule.pdf)

Covered chiropractic services are limited to the treatment to correct a subluxation of the spine

Covered chiropractic CPT codes: 98940, 98941 and 98942

Categories are limited to a maximum of 10 visits

**Please include all documents that support medical necessity for this request**

**Code requested:**

Check appropriate box (choose one):

 [ ] Cervicogenic Headache

 [ ] Spinal Disorders, Cervical

 [ ] Spinal Disorders, Lumbar

 [ ] Strain, Low Back

 [ ] Strain, Neck

**Is the condition the result of a motor vehicle accident?** [ ]  **yes** [ ]  **no**

**Is this condition the result of a work-related injury?** [ ]  **yes** [ ]  **no**

**If yes, document why Worker’s Compensation is not the correct coverage source**

**Diagnoses/Subluxations**:

**Date of onset:** **Date treatment started:** **Number of chiropractic visits this calendar year:**

**Number of additional visits requested:**

**Objective, measurable treatment goals:**

**Criteria Spinal Disorders (check all that apply):**

[ ] Acute < 6 weeks

 [ ] Subacute > 6 weeks

 [ ] Unilateral weakness by physical exam

 [ ] Unilateral pain

 [ ] Unilateral paresthesias

 [ ] Spinal cord compression, cauda equina or myelopathy excluded by history and physical exam

 [ ] Neck or scapular pain

 [ ] Ipsilateral pain localized to neck and head region

 [ ] Pain precipitated by neck movements

 [ ] Limited neck or trunk ROM

 [ ] Low back stiffness

 [ ] Normal neurological examination

Xray:

 [ ] Nondiagnostic for etiology of symptoms

 [ ] Not indicated

**Pain Level:** InitialChoose an item. Current Choose an item.

Radicular or Non-Radicular:

**Location**:

Describe Functional limitations **(check all that apply)**:

 [ ] ADL’s or IADL’s

 [ ] Symptoms

 [ ] Intensity

 [ ] ROM

 [ ] Strength

 [ ] Frequency

**Documented prognosis for clinical or functional improvement**

Progressive Treatment Program

Patient committed to program participation **(must include all)**:

 [ ] Spinal manipulation or manual therapy

 [ ] Therapeutic exercise for strength, ROM, or endurance

 [ ] Documented adherence to home exercise program

Progress made in meeting treatment goals **(check all that apply)**:

 [ ] Reduction in intensity and frequency of symptoms or findings

 [ ] Improvement in function and reduction in limitations:

 [ ] Improved neck ROM

 [ ] Improved muscle strength, reflexes, or atrophy

 [ ] Improved functional performance

 [ ] Decreased pain

 [ ] Endurance

 [ ] Muscle tenderness

 [ ] Spasm

 [ ] Other

To determine the status of a prior authorization, and for any billing issues, please call Provider Services at 1-800-925-1706 or (802) 878-7871.