QualChoice® HEALTH INSURANCE

Chiropractic X-Ray Services Preauthorization Request Form

Section I: Treating Physician Information

Name of Treating Physician	QualChoice ID Number
Name of Clinic (if applicable)	Name of Person Completing this Form
Phone No.	Fax No.

Section II: Member Information

Name of Covered Member	
Date of Birth (MM/DD/YYYY)	QualChoice ID Number
Date of Last X-Ray (MM/DD/YYYY)	Initial Onset Date

Section III: Injury or Complaint

Chief Complaint

Diagnosis Codes

Cause of Current Episode

Has this covered member (patient) been under treatment for more than 2 weeks without a response? ☐ Yes ☐ No

If YES, what type of treatment: _____

If YES, date(s) of treatment: _____

Other studies completed. Mark 'NA' if not applicable.

_____

_____

Service Requested	CPT codes	Number of Views
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rationale For Request

QualChoice Physician Review Signature

X