



Minnesota Health Care Programs (MHCP)

ASSIGNED NUMBER FROM MN-ITS

Chiropractic Authorization Form

Use this form in addition to the MN-ITS Authorization Request transaction or the Authorization Form (DHS-4695) to request authorization for chiropractic services. Fax this form with any additional or required documentation to the medical review agent.

This form must be completed by the treating doctor of chiropractic and attached to each authorization form.

Provider Information

Table with 2 columns: PROVIDER NAME, CONTACT NAME, NPI/UMPI, PHONE NUMBER

Recipient Information

Table with 5 columns: LAST NAME, FIRST NAME, MI, DATE OF BIRTH, MHCP ID NUMBER

Diagnosis section with a large text area for input.

Specific Spinal Subluxations section with sub-sections for CERVICAL, THORACIC, LUMBAR, OTHER.

Onset for this Diagnosis and Exacerbation for this Diagnosis sections with Date and History columns.

Dates of Service for Current Calendar Year section with a table for listing dates.

Subjective Complaints	

Objective Complaints	

Description of Spinal Manipulation

Short Term Goals of Treatment

Long Term Goals of Treatment

Co-morbidities that Could Affect Length of Treatment

Frequency of Requested Visits and Schedule of Declining Frequency	
DATE OF FIRST REQUESTED TREATMENT FOR THIS AUTHORIZATION REQUEST	TOTAL NUMBER OF TREATMENTS REQUESTED
This request is for _____ additional treatments for the month of _____.	This request is for _____ treatments over <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days. (check the appropriate time period)
Frequency of requested visits is: _____ times per week for _____ weeks; and _____ times per week for _____ weeks.	

Emergency Request Briefly explain.

SIGNATURE (OF CHIROPRACTOR)	DATE