Out of Network Chiropractic Prior Authorization Request Form

Use this form before chiropractic services are provided.
Contact Quartz customer service prior to filling out this form by using the number on the back of the card.

**Please complete the entire form and fax to 608-644-3544 or by e-mail to customerservice@quartzbenefits.com*
Incomplete forms will be returned.

Patient completes this section:

Name: _____ Date of Birth: _____

Insurance ID: _____

Reason for Out of Network request:

Patient Activity Impact

Pain Scale [0 1 2 3 4 5 6 7 8 9 10]
No pain Moderate Severe pain

Complaint Frequency [0 25% 50% 75% 100%]
Never Sometimes About half the time Most of the time Constant

How much have your symptoms interfered with your ***SLEEP?***
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How much have your symptoms interfered with your daily ***SOCIAL LIFE*** activities? (i.e. dining out / meeting friends)
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How much have your symptoms interfered with your daily ***RECREATION*** activities? (i.e. walking / running / working out)
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How much have your symptoms interfered with your daily ***TRAVEL*** activities? (i.e. driving / bus / train)
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How much have your symptoms interfered with your daily ***SELF-CARE*** activities? (i.e. grooming / meal prep / restroom)
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How much have your symptoms interfered with your daily ***WORK*** activities? (i.e. sitting / standing / lifting)
❑ 0-Not at all ❑ 1-A little bit ❑ 2-Moderately ❑ 3-Quite a bit ❑ 4-Extremely

How is your symptom interference ***CHANGING***, since receiving treatment at this facility?
❑ 0-First visit ❑ 1-Much better ❑ 2-Better ❑ 3-A little better ❑ 4-No change ❑ 5-A little worse ❑ 6-Worse ❑ 7-Much worse

Provider completes this section:

Provider Name: _____ Provider NPI _____

Clinic NPI _____ Clinic Tax ID Number (TIN): _____

Clinic Name: _____ Physical Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Note: This request does not guarantee payment for services. Benefits will be determined in accordance with the policy terms in effect on the date of service. Please refer to the Policy documents (e.g. Certificate of Coverage, Benefit Riders) for a complete description of plan benefits, limitations, and exclusions. Call Customer Service at the phone number on the back of the insurance ID card.

Service request:

Request Type:	Diagnosis Codes:	Visits and duration request:
Complete and submit form within 3 days of initial visit.	Primary DX: _____	Visit Number: _____
New Injury	Secondary DX: _____	Start Date: _____
Ongoing care	Additional DX: _____	End Date: _____
	_____	

Current Episode Cause:

Motor Vehicle	❑	Trauma	❑
Post-Surgical	❑	Unspecified	❑
Repetitive	❑	Work Related	❑

Nature of Condition:

Initial onset (within last 3 months)	❑
Recurrent (multiple episodes of <3 months)	❑
Chronic (continuous duration >3 months)	❑

Anticipated Risk or Delayed Recovery Attributes:

Anxiety	❑	Diabetes	❑	Post-Surgical	❑	Prescription(s):	
BMI > 40	❑	Inflammatory Arthritis	❑	Pregnancy	❑	Opioids	❑
Cancer	❑	Multiple Episodes	❑	Smoker	❑	Muscle Relaxers	❑
Chronic	❑	Osteoporosis	❑	Radiculopathy	❑	Anti-Inflammation	❑
Depression	❑	Physical Lifestyle	❑	Sedentary Lifestyle	❑		

Provider Comments: [Injury Details] [Exacerbation Details] [Miscellaneous Details] [Other]

Current Pain Scale [0 to 10]:

Pain Location:

- ❑ Localized
- ❑ Pain is Regional
- ❑ Pain Radiates below Knee
- ❑ Pain Radiates below Elbow

Neurology Findings:

- ❑ Reflexes are Normal
- ❑ Reflexes:

	[Absent	Reduced	Normal	Hyper]
❑ Rt upper extremity	0	1	2	3
❑ Lt upper extremity	0	1	2	3
❑ Rt lower extremity	0	1	2	3
❑ Lt lower extremity	0	1	2	3