Rhode Island Medicaid Prior Authorization Form
Chiropractic Services

This form is used to request prior authorization for a Medicaid recipient to receive more than 12 visits in a 365-day period. No prior authorization is needed for the first 12 visits in a 365-day period. The 365-day period is counted from the date of service of the first visit.

Recip MID _____

Last Name_____ First Name_____ Middle _____ Birth Date _____

Ordering, Prescribing, Referring Medicaid Provider Name_____
NPI_____ Taxonomy _____

Performing/Billing Provider Name_____

NPI_____ Taxonomy _____

Return Mailing Address_____

City_____ ST_____ ZIP_____ Phone _____ Fax _____

Date of recipient's first visit: _____

Prior Authorization Start Date: _____ Prior Authorization End Date: _____

Number of chiropractic visits requested for authorization (indicate the number of additional visits requested in the current 365-day period): _____

Procedure Code(s) Requested – check all that apply:
__ 98940
__98941
__98942
Reason service is required, diagnosis/prognosis and treatment described: _____
_____
_____
_____

Performing provider signature and title: _____
Date:_____

OFFICIAL USE DO NOT WRITE BELOW

EOHHS AUTHORIZED _____ **EOHHS DENIED** _____ **DATE** _____

NOTES_____
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