Request Form for Chiropractic Services Clinical Criteria

Date:

Complete this form if you'd like to know the clinical criteria we use to make medical necessity determinations for coverage. This form is for clinical criteria requests only, and can't be used to request coverage for services or authorization of services.

It may be completed by a member or potential member, or by a doctor or other provider on their behalf.

Contact Information		
Name:		
Address 1:	**Address 2:**	
City:	**State:**	**ZIP:**
Phone:	**Fax** (optional)**:**	

Are you currently a member or provider of Blue Cross Blue Shield of Massachusetts?

□ Yes □ No

Select the specific conditions so we can send you the appropriate criteria.

- ☐ Cervical /Neck complaints
- ☐ Lumbar/Low back complaints
- ☐ Headache
- ☐ Shoulder complaints

How do you prefer to receive this information? (Check one)

□ U.S. Mail □ Fax

If you elect to receive this information via fax you are consenting to receive a response at the fax number provided above.

How to Submit This Form

U.S. Mail:

ATTN: WHL Clinical Criteria Request
4031 Aspen Grove Drive, Suite 250
Franklin, TN 37067

Email: Clinicalcriteria@tivityhealth.com

Fax: 888-492-1029