PIEDMONT COMMUNITY HEALTH PLAN
Community Partners for Quality Healthcare

Chiropractic Services Treatment Plan

I. TO: Piedmont Community Health Plan (PCHP) FAX No: 434-947-4465

FROM: _____ — Chiropractic Services

PATIENT'S NAME: _____

SSN# ON INSURANCE CARD: _____

PCP: _____ **FAX No:** _____

EMPLOYER: _____

CHIROPRACTIC SERVICES FAX No: _____

Discussion with several chiropractic offices revealed the issue for a form that would document the treatment plan and approval by PCHP for the files, as opposed to the provider giving this information to PCHP by phone. As a result, PCHP will provide this form with all referrals for chiropractic services.

Please complete the information required on this form including the demographic information in Section I, and the treatment plan, Section II for the referred patient. Upon completion, fax this form to PCHP. Upon approval of the treatment plan, PCHP will complete Section III of this form and fax it to the providers; both the Primary Care Physician and the Chiropractor.

II. CHIROPRACTIC THERAPY TREATMENT PLAN
(Therapy limited to 4-6 weeks treatment plan, no more than 3 visits per week without a call to PCHP)

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***All treatment not outlined above will require contact with the Primary Care Physician and an updated referral to Piedmont Community Health Plan.**

III. Approved: _____ **Comments:** _____

Signed: _____ **Date:** _____

<u>NOTE</u>: APPROVAL OF THIS TREATMENT PLAN DOES NOT APPROVE PAYMENT BEYOND BENEFIT DESIGN.