

CHIROPRACTIC PROGRAM

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This chapter contains information about our network and utilization management program for chiropractic services provided to designated members.

CHIROPRACTIC PROGRAM OVERVIEW

EmblemHealth has partnered with Palladian Muscular Skeletal Health (Palladian), a specialty network and utilization management organization, to arrange chiropractic services for our members in the benefit plans listed below. Through this partnership, Palladian is responsible for the administration of prior approvals, claims payment, credentialing, recredentialing and appeals for denial determinations, as described in this chapter.

- GHI HMO
- GHI HMO - Point of Service
- GHI HMO - Senior Supplement (Commercial)
- GHI PPO
- HIP Access I and HIP Access II
- HIP Prime (HMO)
- HIP Prime (POS)
- EmblemHealth Medicare HMO
- EmblemHealth Medicare PPO
- Vytra HMO

Members and eligible dependents covered by these plans are allowed unlimited visits to a network chiropractor, based on medical necessity and the meeting of prior approval and referral requirements (according to the member's benefit).

All members excluded from the Chiropractic Program are medically managed in the same way as they are for all other services and are subject to consistent utilization review and utilization management standards and protocols.

PRIOR APPROVALS AND REFERRALS

HIP and Vytra HMO Plans

The initial visit to a chiropractor does not require prior approval. Chiropractors must obtain prior approval from Palladian for the member's second treatment, and each continued treatment thereafter, by completing and submitting the medical necessity review forms online by signing in to www.palladianhealth.com or by faxing them to **1-716-712-2802** for HIP members or to **1-716-712-2803** for Vytra members.

GHI HMO Plans

The practitioner providing care or the ordering specialist must provide members with a referral for them to obtain chiropractic services. This initial referral is valid for the first six visits to the participating chiropractor. Within three business days of the initial evaluation, the referred chiropractor must complete and submit the Referral Certification Form online or via fax.

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To complete and submit the form for the first six visits and any additional visits thereafter, referred chiropractors may complete and submit the Referral Certification Form online after logging into www.palladianhealth.com. They may also fax the completed form (found at the end of this chapter) to **1-716-712-2817**. Palladian will then register the visits.

GHI PPO Plans

Members may access chiropractic care without a referral or prior approval for no less than the first eight visits, depending on the member's benefit. Chiropractors must obtain prior approval from Palladian for each continued treatment thereafter by submitting the medical necessity review forms online by logging onto www.palladianhealth.com or by faxing them to **1-716-712-2817**.

NOTE: Failure to submit required forms for additional authorization may result in an administrative denial.

SUBMITTING REQUESTS FOR MEDICAL REVIEW

Medical necessity determinations for future care are based on the completion of three concise clinical intake forms:

- **The Chiropractic Treatment Form** - completed by the participating therapist
- **The Chiropractic Intake Form** - completed by the patient
- **The Chiropractic Outcomes Form** - completed by the patient; or the **Pediatric Outcomes Form** - completed by the parent or guardian of patients under the age of 18

These forms are on www.emblemhealth.com and on www.palladianhealth.com. The practitioner is responsible for submitting all forms to Palladian for review. Practitioners may submit the completed forms electronically by logging onto www.palladianhealth.com or they may fax them to Palladian at **1-716-809-8324**.

Following are examples of the forms required for different scenarios:

- For every new patient and when there is a change in the primary diagnosis, the following three forms need to be submitted within five business days of the initial evaluation.
 - **Chiropractic Treatment Form** - completed by the therapist
 - **Chiropractic Intake Form** - completed by the patient
 - **Chiropractic Outcomes Form** - completed by the patient
- For any additional follow-up care after the initial authorization, the following two forms need to be submitted within five business days of the "Requested Start Date."
 - **Chiropractic Treatment Form** - completed by the therapist
 - **Chiropractic Outcomes Form** - completed by the patient

All requests for additional care may be submitted to www.palladianhealth.com.

APPEALS

For **Commercial members**, appeals for denial determinations made by Palladian must be

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submitted to:

Palladian Muscular Skeletal Health
Attn: UM Department
2732 Transit Road
West Seneca, NY 14224

For **Medicare members**, appeals for denial determinations made by Palladian must be submitted to:

EmblemHealth
Grievance and Appeals Department
P.O. Box 2807
New York, NY 10116-2807

CUSTOMER SERVICE

Eligible members may call the following numbers for customer service and more information:

- HIP: **1-877-774-7693**
- GHI PPO: **1-212-501-4444** (in New York City) or **1-315-432-0826** (in all other areas)
- Medicare PPO: **1-866-557-7300**
- GHI HMO: **1-866-284-2901**
- Vytra: **1-866-883-0643**

CREDENTIALING

Palladian is responsible for the credentialing and recredentialing of participating chiropractors for GHI HMO and HIP. EmblemHealth EPO/PPO and GHI PPO providers contract directly with the plan. Please refer to the chart below:

BENEFIT PLAN	PALLADIAN	EMBLEMHEALTH
GHI HMO	Yes	
HIP	Yes	
Vytra	Yes	
EmblemHealth EPO/PPO		Yes
GHI PPO (Commercial)		Yes
Medicare Choice PPO		Yes

CLAIMS



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Claims must be submitted in the following manner:

BENEFIT PLAN	ADDRESS	FORM REQUIRED
HIP and Vytra HMO	Palladian Muscular Skeletal Health P.O. Box 368 Lancaster, NY 14086-0368 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
GHI HMO	Palladian Muscular Skeletal Health P.O. Box 307 Lancaster, NY 14086 For electronic claims submission, Palladian's Payor ID is 37268.	CMS-1500
GHI PPO (Commercial)	GHI Claims P.O. Box 2832 New York, NY 10116	CMS-1500
Medicare Choice PPO	EmblemHealth Medicare PPO P.O. Box 2830 New York, NY 10116-2830	CMS-1500

FORMS

See the following pages for our Chiropractic Program forms:

- **Chiropractic Intake Form**
- **Chiropractic Outcomes Form**
- **Chiropractic Pediatric Outcomes Form**
- **Chiropractic Treatment Form**



**DC Patient Intake Form
(version 1.1)**

www.palladianhealth.com/members



Last name	First name
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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

- | | | | |
|--|--------------------------------|-----------------------------|--------------------------------|
| <input type="radio"/> Neck | <input type="radio"/> Shoulder | <input type="radio"/> Hip | <input type="radio"/> Headache |
| <input type="radio"/> Upper/
mid back | <input type="radio"/> Elbow | <input type="radio"/> Knee | <input type="radio"/> Other |
| <input type="radio"/> Lower back | <input type="radio"/> Wrist | <input type="radio"/> Ankle | |
| | <input type="radio"/> Hand | <input type="radio"/> Foot | |

2. When did this problem first begin?

- Less than 1 month ago
 1-3 months ago
 4-6 months ago
 7-12 months ago
 More than 1 year ago

Has this problem...	No	Yes
3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?	<input type="radio"/>	<input type="radio"/>
4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	<input type="radio"/>	<input type="radio"/>
5. ... recently been evaluated by a medical doctor?	<input type="radio"/>	<input type="radio"/>
Since this problem began, have you noticed...	No	Yes
6. ... so much weakness in both your arms that you are unable to lift them?	<input type="radio"/>	<input type="radio"/>
7. ... so much weakness in both your legs that you are unable to walk without help?	<input type="radio"/>	<input type="radio"/>
8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?	<input type="radio"/>	<input type="radio"/>
9. ... pain in your chest, shortness of breath, or coughing up blood?	<input type="radio"/>	<input type="radio"/>
10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?	<input type="radio"/>	<input type="radio"/>
Have you recently...	No	Yes
11. ... had blurred vision, double vision, dizziness, or fainting?	<input type="radio"/>	<input type="radio"/>
12. ... had any type of infection, fever, or chills?	<input type="radio"/>	<input type="radio"/>
13. ... had any type of surgery, surgical procedure, or medical procedure?	<input type="radio"/>	<input type="radio"/>
14. ... lost a lot of weight without really trying to (i.e. without being on a diet)?	<input type="radio"/>	<input type="radio"/>
15. ... had any type of accident, fall, or trauma?	<input type="radio"/>	<input type="radio"/>
Have you ever...	No	Yes
16. ... been diagnosed with cancer?	<input type="radio"/>	<input type="radio"/>
17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	<input type="radio"/>	<input type="radio"/>
18. ... been diagnosed with a weakened immune system?	<input type="radio"/>	<input type="radio"/>
19. ... used any injected drugs (i.e. non-prescription drugs)?	<input type="radio"/>	<input type="radio"/>
20. ... used steroids such as prednisone for more than 4 weeks?	<input type="radio"/>	<input type="radio"/>
Is this problem something that ...	No	Yes
21. ... you've had before?	<input type="radio"/>	<input type="radio"/>
22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?	<input type="radio"/>	<input type="radio"/>
23. ... generally gets better (i.e. less severe or frequent) with rest?	<input type="radio"/>	<input type="radio"/>
24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	<input type="radio"/>	<input type="radio"/>
25. ... is also being treated by a health professional other than a chiropractor?	<input type="radio"/>	<input type="radio"/>

Service Date: / /

M M / D D / Y Y Y Y

Draft





**DC Patient Outcomes Form
(version 1.1)**

www.palladianhealth.com/members



PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name		First Name											
<p>1. In general, would you say your health is</p> <p style="text-align: right;">Excellent Very good Good Fair Poor</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?</p>													
<p>2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</p> <p style="text-align: right;">Yes, limited a lot Yes, limited a little No, not limited at all</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>3. Climbing several flights of stairs</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?</p>													
<p>4. Accomplished less than you would like</p> <p style="text-align: right;">All of the time Most of the time Some of the time A little of the time None of the time</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>5. Were limited in the kind of work or other activities</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?</p>													
<p>6. Accomplished less than you would like</p> <p style="text-align: right;">All of the time Most of the time Some of the time A little of the time None of the time</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>7. Did work or other activities less carefully than usual</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>8. During the <u>past week</u>, how much did pain interfere with your normal work (including work outside the home and housework)?</p> <p style="text-align: right;">Not at all A little bit Moderately Quite a bit Extremely</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.</p>													
<p>How much of the time during the <u>past week</u>...</p>													
<p>9. Have you felt calm and peaceful?</p> <p style="text-align: right;">All of the time Most of the time Some of the time A little of the time None of the time</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>10. Did you have a lot of energy?</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>11. Have you felt downhearted and depressed?</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>12. During the <u>past week</u>, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?</p> <p style="text-align: right;">All of the time Most of the time Some of the time A little of the time None of the time</p> <p style="text-align: right;"><input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/></p>													
<p>How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?</p>													
	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date: / /

M M / D D / Y Y Y Y

45804



DC Pediatric Outcomes Form
(version 1.1)

www.palladianhealth.com/members



37283

Last Name	First Name
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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. In general, would you say your child's health is

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the past week, has your child been limited in any of the following activities due to HEALTH problems?

2. Doing things that take some energy such as riding a bike or skating?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Bending, lifting, or stooping?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of PHYSICAL health problems?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. During the past week, has your child been limited in the KIND of schoolwork or activities with friends he/she could do because of EMOTIONAL or BEHAVIORAL problems?

Yes, limited a lot	Yes, limited some	Yes, limited a little	No, not limited
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. During the past week, how much bodily pain or discomfort has your child had?

None	Very mild	Mild	Moderate	Severe	Very Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. During the past week, how satisfied do you think your child has felt about his/her friendships?

Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. During the past week, how satisfied do you think your child has felt about his/her life overall?

Very satisfied	Somewhat satisfied	Neither satisfied nor dissatisfied	Somewhat dissatisfied	Very dissatisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. During the past week, how much of the time do you think your child acted bothered or upset?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Compared to other children your child's age, in general would you say his/her behavior is:

Excellent	Very good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate the severity of your child's main health problem on a scale from 0 to 10?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
11. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
12. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
13. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date: / /

M M / D D / Y Y Y Y

37283



ICD-10 DC Treatment Form
(version 2.1)
www.palladianhealth.com/providers



17761

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)
V:PalladianDCTreatment(2.1)20150901

Section A. Provider information														
First Name						NPI								
Last Name														
Facility Name						State								
Service Add.						Zip								
Section B. Patient information														
First Name						Date of Birth	M	M	D	D	Y	Y	Y	Y
Last Name						Onset								
Health Plan						Last Visit								
Member ID						Requested Start								
Section C. Primary region of complaint (select only 1 region) and primary diagnosis (ICD-10 number or text description)														
<input type="radio"/> Cervical Shoulder <input type="radio"/> L <input type="radio"/> R Hip <input type="radio"/> L <input type="radio"/> R <input type="radio"/> Headache <input type="radio"/> C/S+radiculopathy Elbow <input type="radio"/> L <input type="radio"/> R Knee <input type="radio"/> L <input type="radio"/> R <input type="radio"/> Other <input type="radio"/> Thoracic Wrist <input type="radio"/> L <input type="radio"/> R Ankle <input type="radio"/> L <input type="radio"/> R <input type="radio"/> Lumbosacral Hand <input type="radio"/> L <input type="radio"/> R Foot <input type="radio"/> L <input type="radio"/> R <input type="radio"/> L/S+radiculopathy		Authorization Request for: <input type="radio"/> Treatment only <input type="radio"/> X-ray only <input type="radio"/> Both		ICD-10 <input type="text"/>										
Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology) and X-rays														
Does this patient have any red flags (e.g. "yes" answers to DC Patient Intake Form questions 6-20)? <input type="radio"/> No <input type="radio"/> Yes														
Does this patient have any contraindications to receiving DC care from you for this complaint? <input type="radio"/> No <input type="radio"/> Yes														
X-rays: <input type="radio"/> None <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Other X-ray CPT Code <input type="text"/>														
Rule out: <input type="radio"/> Fracture <input type="radio"/> Instability <input type="radio"/> Infection <input type="radio"/> Malignancy <input type="radio"/> Systemic inflammatory disease <input type="radio"/> Other														
Section E. Neurologic involvement associated with any spine condition														
Which of the following <u>symptoms or signs of neurologic involvement</u> are present in the extremities?														
Symptoms: <input type="radio"/> None <input type="radio"/> Radiating Pain <input type="radio"/> Paresthesia <input type="radio"/> Weakness														
Signs: <input type="radio"/> None <input type="radio"/> Decreased sensation <input type="radio"/> Abnormal DTRs <input type="radio"/> Decreased strength <input type="radio"/> Pathologic reflex														
What is the overall <u>severity of the neurologic involvement</u> associated with this spine condition?														
<input type="radio"/> None <input type="radio"/> Very mild <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Very severe														
Section F. Evaluation														
Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary spine condition? Please choose <u>one</u> box for each of these columns.														
Symptoms	Physical function	Overall health	Prognosis											
<input type="radio"/> Very mild	<input type="radio"/> Very good	<input type="radio"/> Very good	<input type="radio"/> Very good											
<input type="radio"/> Mild	<input type="radio"/> Good	<input type="radio"/> Good	<input type="radio"/> Good											
<input type="radio"/> Moderate	<input type="radio"/> Moderate	<input type="radio"/> Moderate	<input type="radio"/> Moderate											
<input type="radio"/> Severe	<input type="radio"/> Poor	<input type="radio"/> Poor	<input type="radio"/> Poor											
<input type="radio"/> Very severe	<input type="radio"/> Very poor	<input type="radio"/> Very poor	<input type="radio"/> Very poor											
Section G. Management plan (i.e. how you plan on managing this patient's complaint)														
Education about:	<input type="radio"/> Diagnosis	<input type="radio"/> Prognosis	<input type="radio"/> Remaining active	<input type="radio"/> Other	<input type="radio"/> None									
Home/self-care:	<input type="radio"/> Heat/ice	<input type="radio"/> General exercises	<input type="radio"/> Specific exercises	<input type="radio"/> Other	<input type="radio"/> None									
Supervised exercise:	<input type="radio"/> Strengthening	<input type="radio"/> Stretching	<input type="radio"/> Stabilization	<input type="radio"/> Other	<input type="radio"/> None									
Modalities:	<input type="radio"/> Heat/ice	<input type="radio"/> TENS/EMS	<input type="radio"/> Ultrasound	<input type="radio"/> Other	<input type="radio"/> None									
Manual therapy:	<input type="radio"/> Manipulation	<input type="radio"/> Mobilization	<input type="radio"/> Soft tissue	<input type="radio"/> Other	<input type="radio"/> None									
Number of DC visits used since last DC Treatment Form was submitted:														
<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 <input type="radio"/> Other														
Phone <input type="text"/> - <input type="text"/> - <input type="text"/>					Fax <input type="text"/> - <input type="text"/> - <input type="text"/>									

Provider signature: Date / /

Note: By completing and signing this form, the provider indicates that they:
1. provided all services, and 2. are a participating provider, and 3. provided all services in a credentialed practice.

