Chiropractor Referral

Must be completed by a primary care provider

This referral is subject to the limitations and requirements of the member's Summary Plan Description. This is not a guarantee of coverage.

Date of Request: _____

Patient/Member Name: _____

Member ID: _____

Chiropractor being referred to (if known)*: _____

*The member is responsible for seeing a participating/contracted chiropractor.

REFERRING PROVIDER INFORMATION:

Note: The referring provider must be a primary care provider in order for the referral to be accepted.

Referring Primary Care Provider Name: _____

Referring Primary Care Provider NPI: _____

This form can be emailed, mailed or faxed to the plan administrator:

Email: *Team-ClaimsSupport@healthalliance.org

Mail: Health Alliance Medical Plans
3310 Fields South Drive
Champaign, IL 61822-3741

Fax: 217-902-9777