THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Chiropractic Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfChiropracticExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfChiropracticExaminers*

Request for Utilization Review Instructions

In 1998, the Alaska Board of Chiropractic Examiners established a Utilization Review Committee in accordance with AS 08.20.185. The committee is comprised of four members: three chiropractic physicians and one public member. Members of the committee must qualify under all appropriate statutes and regulations, and are appointed based upon their active interest, diverse experience, understanding of the occupation, integrity, etc.

The purpose of the committee is to review complaints concerning the reasonableness or appropriateness of care provided, fees charged, and/or costs for services rendered by a licensee to a patient. The committee will act in an advisory capacity to the board.

Findings of the committee include a determination of whether the chiropractic physician provided or ordered appropriate treatment or services, and whether fees charged are a reasonable and appropriate cost of treatment.

The committee reports findings to the board and furnishes a copy of its findings to the patient, chiropractic physician, and insurer involved in the case. The committee must file a complaint with the investigative unit if there is cause to believe that a chiropractic physician has violated any portion of the Alaska Chiropractic Act for which a licensee may be disciplined.

REQUEST PROCEDURES

The following must be received by the division before your Request for Utilization Review can be reviewed:

1. REQUEST
A signed, completed request (#08-4371, pages 1-2). The request can be completed by a patient, patient's representative, insurer or chiropractic physician.

2. FEES
Fees made payable to "State of Alaska."
Peer Review Fee: $ 50.00

3. AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS
A completed Authorization for Disclosure of Health Records form (#08-4371a).

CONFIDENTIALITY:
A chiropractic physician involved in a utilization review case must submit to the committee all necessary records and other information concerning the patient's treatment. Patient records presented to the committee for review that were confidential before their presentation must remain confidential to the committee members and to the board members.

AUTHORITY:
The board maintains disciplinary powers under AS 08.01.075. The findings of the committee may be utilized by the board in considering disciplinary action against a licensee, but the results or recommendations of the committee are not binding upon the board.

A licensee's acceptance of or request for payment for treatment given to a patient constitutes the licensee's consent to submit to utilization review.

A member of a utilization review committee who in good faith submits a report or participates in an investigation or judicial proceeding related to a report is immune from civil liability for the submission or participation.

DEFINITIONS:
"Appropriate treatment of services" means treatment or services performed, because of a substantiated and properly diagnosed condition, that are consistent with that diagnosis as reviewed by the utilization review committee.

"Licensee" means a chiropractic physician licensed under AS 08.20.

"Reasonable and appropriate cost of treatment" means that charges submitted for services performed are necessary and reasonable charges in the judgment of the utilization review committee.

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Request for Utilization Review

PART I Payment of Fees

Required Fees:	☐ Peer Review Fee	**$50.00**

PART II Chiropractor Information

Chiropractor Name:		**AK License Number:**	
Mailing Address:	P.O. Box or Street / City / State / Zip		
Email Address:		**Contact Phone:**	

PART III Patient Information

Patient Name:			
Mailing Address:	P.O. Box or Street / City / State / Zip		
Email Address:		**Contact Phone:**	
Claim Number:		**Policy Number:**	

PART IV Insurance Information

Insurance:			
Contact Person			
Mailing Address:	P.O. Box or Street / City / State / Zip		
Email Address:		**Contact Phone:**	

PART V Reason for Request

Describe the specific reason(s) for requesting a utilization review below:

PART VI Signature

I hereby certify the above information is true and complete to the best of my knowledge.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

Requestor Signature:		**Date Signed:**	
Requestor Name:			
This form completed and submitted by:	☐ Patient ☐ Doctor ☐ Insurance		

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Authorization for Disclosure of Health Records

Patient Name:		**Date of Birth:**	
Mailing Address:	P.O. Box or Street City State Zip		
Email Address:		**Contact Phone:**	

☐ I authorize _____ to disclose my protected health information as follows:

Check all that apply:

- ☐ Complete Medical Record for all services to include: History and Physical Exam; Progress Notes; Laboratory Tests, Physician Orders, X-ray Reports, Inpatient Admissions, Physical Therapy.
- ☐ Records related only to the following date(s) of service: _____
- ☐ Athletic Injury Status. Specify Information below.

Signature

I hereby certify the above information is true and complete to the best of my knowledge.

Patient Name			
Patient Signature:		**Date Signed:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type *(e.g., Acupuncture)*:		**License Number *(if applicable)*:**	
I wish to make payment by credit card for the following *(check all that apply):*			**AMOUNT**
☐ **Application Fee:**			
☐ **License or Renewal Fee:**			
☐ **Other *(fine, exam, etc.)*:**			
1.			
2.			
		TOTAL:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		