

FEE SCHEDULE REVISION FORM

Clinic Name: _____

Date: _____

CPT CODE	ACTUAL FEE	CURRENT CHUSA FEE	NEW CHUSA FEE	CPT CODE	ACTUAL FEE	CURRENT CHUSA FEE	NEW CHUSA FEE
98940				97010			
98941				97012			
98942				97014			
98943				97032			
				97035			
				97039			
99202							
99203				97110			
99204				97112			
99205				97124			
				97140			
99212				97530			
99213				97535			
99214							
99215				OTHER			
CAPPED FEES		CURRENT	NEW	OTHER			
New Patient Visit				OTHER			
Routine Visit				OTHER			
Other:				OTHER			

COMMENTS:

Reminder: If you are increasing your CHUSA fees, you must honor the fee schedule in place for all patients enrolled under your previous fee schedule until their anniversary dates. **FAX:** 888-685-2220 or **EMAIL:** fees@chirohealthusa.com

FEE SCHEDULE REVISION FORM

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FAMILY PLAN (optional)*

*Family discounts MUST be greater than the first patient.

NEW PATIENT VISIT

PRIMARY % reduction of normal clinic fees
MEMBER: with a maximum fee of \$

2ND PATIENT % reduction of normal clinic fees
FAMILY MEMBER: with a maximum fee of \$

3RD & SUBSEQUENT % reduction of normal clinic fees
FAMILY MEMBERS: with a maximum fee of \$

ROUTINE OFFICE VISIT

PRIMARY % reduction of normal clinic fees
MEMBER: with a maximum fee of \$

2ND PATIENT % reduction of normal clinic fees
FAMILY MEMBER: with a maximum fee of \$

3RD & SUBSEQUENT % reduction of normal clinic fees
FAMILY MEMBERS: with a maximum fee of \$

ROUTINE OFFICE VISIT STIPULATIONS:

In order to receive the family plan discount, the family member must be seen:

_____ same day _____ same week _____ same month _____ no stipulations

ADDITIONAL COMMENTS:

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