OON Medical Records Cover Sheet (Use One per Patient)

PRACTITIONER NAME: TIN #______________

PRACTITIONER ADDRESS:

Practitioner Phone#:______________

Practitioner FAX #:______________

(Providing your FAX # will expedite the response to this request)

*NPI # (Type 1-Ind)*______________ *NPI # (Type 2-Org)*______________

To: American Specialty Health	Date:
Fax: Within CA ONLY: 1.877.427.4777 Outside of CA: 1.877.304.2746	Pages:
Patient Name: Pt. Birth date:	Patient ID#: Gender: ☐ Male ☐ Female
Subscriber Name: Subscriber ID#:	Health Plan: Group #:

TREATMENT / SERVICES SUBMITTING FOR REVIEW

Diagnoses (ICD Code): 1.______________ 3.______________

2.______________ 4.______________

Date Range: From ____/____/______ Through ____/____/______

# of E & M Services: ☐ New Pt. Exams ☐ Est. Pt. Exams

# of Visits (Includes 98940-98943 Codes) during date range: ☐

Are you requesting review for Extraspinal CMT services (98943)? ☐ Yes

# of Modalities/Procedures (97000-97545) during date range: ☐

List Modalities/Procedures (by CPT):______________

OTHER SERVICES WITHIN THE ABOVE DATE RANGE YOU ARE SUBMITTING FOR REVIEW:

Durable Medical Equipment by HCPCS Code(s):______________ Date:________

Consultation/Preventive Services by CPT Code(s):______________ Date:________

Prolonged/Special Services by CPT Code(s):______________ Date:________

Electrodx. &/or Lab studies by CPT Codes(s):______________ Date:________

Imaging / Other Studies by CPT Code(s):______________ Date:________

Other Services by CPT/HCPCS Code(s):______________ Date:________

By submitting this *Medical Records Cover Sheet*, I attest that the above dates and services are those I wish to have reviewed for medical necessity.

Please attach all relevant Exam Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.

Clinical Information Summary Sheet

Practitioner Name____________________

Patient Name____________________

I. Historical Information

CHIEF COMPLAINT(s) with date(s) of onset: (mm/dd/yy) ____________________

Mech. of Injury/Exacerbation____________________

Pertinent Past History / Co-Morbidities____________________

II. Examination Information

Date of Exam ____ /____ / ____

Vital Signs: Height ____ Weight ____ Blood Pressure ____ Temp ____

Range of Motion

Cervical spine: ☐ N/A ☐ All WNL **Flexion** ___/60 or___% limited **Extension** ___/50 or___% limited

Lateral Flexion: Left ___/40 or___% limited Right ___/40 or___% limited

Rotation: Left ___/80 or___% limited Right ___/80 or___% limited

Comments____________________

Lumbo-sacral: ☐ N/A ☐ All WNL **Flexion** ___/90 or___% limited **Extension** ___/30 or___% limited

Lateral Flexion: Left ___/20 or___% limited Right ___/20 or___% limited

Rotation: Left ___/30 or___% limited Right ___/30 or___% limited

Comments:____________________

Extremity / Other:____________________

Ortho / Neuro / Vascular / VBI: ☐ NA ☐ WNL (Please include location and intensity of any findings.)____

Chiropractic / Palpation / Postural Assessment____________________

Functional Assessment / Improvement____________________

III. Therapeutic Goals And Outcome Assessments

Therapeutic Goals____________________

Exercise/Home Care Instructions____________________

Outcome Assessments: ☐ N/A **Date score obtained:** ____________

☐ Neck Disability score: Initial ____ Current ____ ☐ Roland-Morris score: Initial ____ Current ____

☐ Oswestry score: Initial ____ Current ____ ☐ Perceived Improvement ____________%

☐ Other (name) score: Initial ____ Current ____

ADDITIONAL COMMENTS____________________

Signature of treating D.C. (Required)____________________ **Date**____________