Chiropractic OON Medical Records Cover Sheet

(Use One Per Patient)

PRACTITIONER NAME:	TIN #:
PRACTITIONER ADDRESS: *NPI # (Type 1-Ind):* _____	Practitioner Phone #: Practitioner FAX #: (Providing your FAX # will expedite the response to this request) *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: Patient 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 of Submitted Services for Review: From: ___/___/___ Through: ___/___/___

# of E & M Services: ☐ New Pt. Exams ☐ Est. Pt. Exams Date of Requested Exam: _____

# of Visits (Includes 98940-98943 Codes) within the above date range: ☐

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

# of Modalities/Procedures (97000-97545) within the above date range: ☐

List Modalities/Procedures by CPT: _____
(for timed therapies include units per date of service)

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

X-Ray/Other Studies by CPT Code(s): _____ Date: _____

Durable Medical Equipment by HCPCS Code(s): _____ Date: _____

Electrodx./Prolonged/Special Services by CPT Code(s): _____ Date: _____

Other Services by CPT/HCPS 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 Clinical Information Summary Sheet (CISS) or all relevant Exam Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.