****GO ELECTRONIC ****

The area enclosed by the dashed line is already completed for you when you use ASHLink online forms.

ASHLink also allows:

- Verifying patient eligibility and benefit info.
- Passing batch claims to ASH Clearinghouse
- Getting paid faster with Direct Deposit
- Incentives for using ASHLink

This MNR form is for PT, OT or AT Neurologic Conditions

For the condition you are currently treating:

Enter the date of first visit, AND the TOTAL number of visits you have already provided

Include ALL diagnoses that will be treated during requested dates

Enter the dates you are requesting for this authorization, and the total number of visits being requested within those dates

List any additional codes that require specific review and the number of each needed.

Provide a description of balance or gait deviations when appropriate. Include name and if there is use of assistive device

Request eval/re-eval only if it occurs during the dates requested AND submit the findings from that exam and the date performed

Findings below should be **at or before** your requested start date

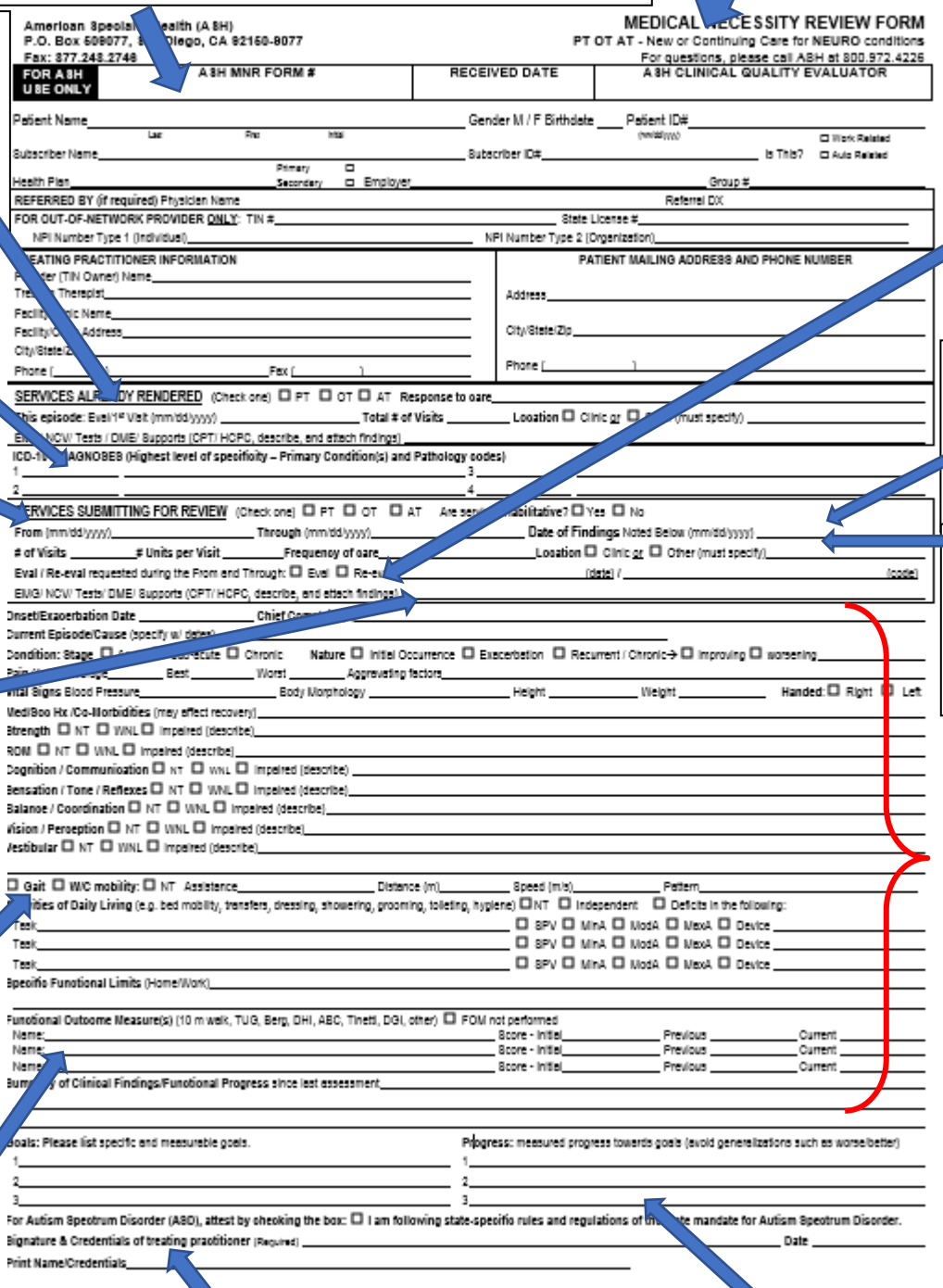
This is where treatment is occurring (e.g. clinic, home, gym, etc.)

Document the clinically relevant, measurable/trackable findings that support care, diagnoses, and illustrate current patient status

Provide name and score of the Functional Outcome Measure used, be consistent with same test across multiple MNR requests

The MNR Form must be signed and dated by the treating clinician whose name appears above as well. Supervising therapist MUST co-sign for PTAs or COTAs. Should be legible

Include any specific goals relevant to the requested treatment dates. Note the measured progress to date



American Specialty Health (A SH)
P.O. Box 609077, San Diego, CA 92160-8077
Fax: 877.248.2748

MEDICAL NECESSITY REVIEW FORM
PT OT AT - New or Continuing Care for NEURO conditions
For questions, please call ASH at 800.972.4226

FOR A SH USE ONLY | A SH MNR FORM # | RECEIVED DATE | A SH CLINICAL QUALITY EVALUATOR

Patient Name (Last, First, Init) Gender M / F Birthdate (mm/dd/yyyy) Patient ID#
Subscriber Name Subscriber ID# Is This? Work Related Auto Related
Health Plan Primary Secondary Employer Group #
REFERRED BY (if required) Physician Name Referral DX
FOR OUT-OF-NETWORK PROVIDER ONLY: TIN # State License #
NPI Number Type 1 (Individual) NPI Number Type 2 (Organization)

TREATING PRACTITIONER INFORMATION
Provider (TIN Owner) Name
Treating Therapist
Facility Name
Facility Address
City/State/Zip
Phone ( ) Fax ( )

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address
City/State/Zip
Phone ( )

SERVICES ALREADY RENDERED (Check one) PT OT AT Response to care
This episode: Eval/1st Visit (mm/dd/yyyy) Total # of Visits Location Clinic or Other (must specify)
EMG/ NCV/ Tests / DME/ Supports (CPT/ HCPC, describe, and attach findings)
ICD-10 DIAGNOSES (Highest level of specificity – Primary Condition(s) and Pathology codes)
1 3
2 4

SERVICES SUBMITTING FOR REVIEW (Check one) PT OT AT Are services habilitative? Yes No
From (mm/dd/yyyy) Through (mm/dd/yyyy) Date of Findings Noted Below (mm/dd/yyyy)
# of Visits # Units per Visit Frequency of care Location Clinic or Other (must specify)
Eval / Re-eval requested during the From and Through: Eval Re-eval (date) / (code)
EMG/ NCV/ Tests/ DME/ Supports (CPT/ HCPC, describe, and attach findings)
Onset/Exacerbation Date Chief Complaint
Current Episode/Cause (specify w/ dates)
Condition: Stage Acute Subacute Chronic Nature Initial Occurrence Exacerbation Recurrent / Chronic→ Improving worsening
Pain Level: Type Best Worst Aggravating factors
Initial Signs Blood Pressure Body Morphology Height Weight Handed: Right Left
Medical Hx /Co-Morbidities (may affect recovery)
Strength NT WNL Impaired (describe)
ROM NT WNL Impaired (describe)
Cognition / Communication NT WNL Impaired (describe)
Sensation / Tone / Reflexes NT WNL Impaired (describe)
Balance / Coordination NT WNL Impaired (describe)
Vision / Perception NT WNL Impaired (describe)
Vestibular NT WNL Impaired (describe)
Gait W/C mobility: NT Assistance Distance (m) Speed (m/s) Pattern
Activities of Daily Living (e.g. bed mobility, transfers, dressing, showering, grooming, toileting, hygiene) NT Independent Deficits in the following:
Task SBV MinA ModA MaxA Device
Task SBV MinA ModA MaxA Device
Task SBV MinA ModA MaxA Device
Specific Functional Limits (Home/Work)

Functional Outcome Measure(s) (10 m walk, TUG, Berg, DHI, ABC, Tinetti, DGI, other) FOM not performed
Name: Score - Initial Previous Current
Name: Score - Initial Previous Current
Name: Score - Initial Previous Current
Summary of Clinical Findings/Functional Progress since last assessment

Goals: Please list specific and measurable goals.
1
2
3

Progress: measured progress towards goals (avoid generalizations such as worse/better)
1
2
3

For Autism Spectrum Disorder (ASD), attest by checking the box: I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder.
Signature & Credentials of treating practitioner (Required) Date
Print Name/Credentials