****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 Orthopedic 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

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

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

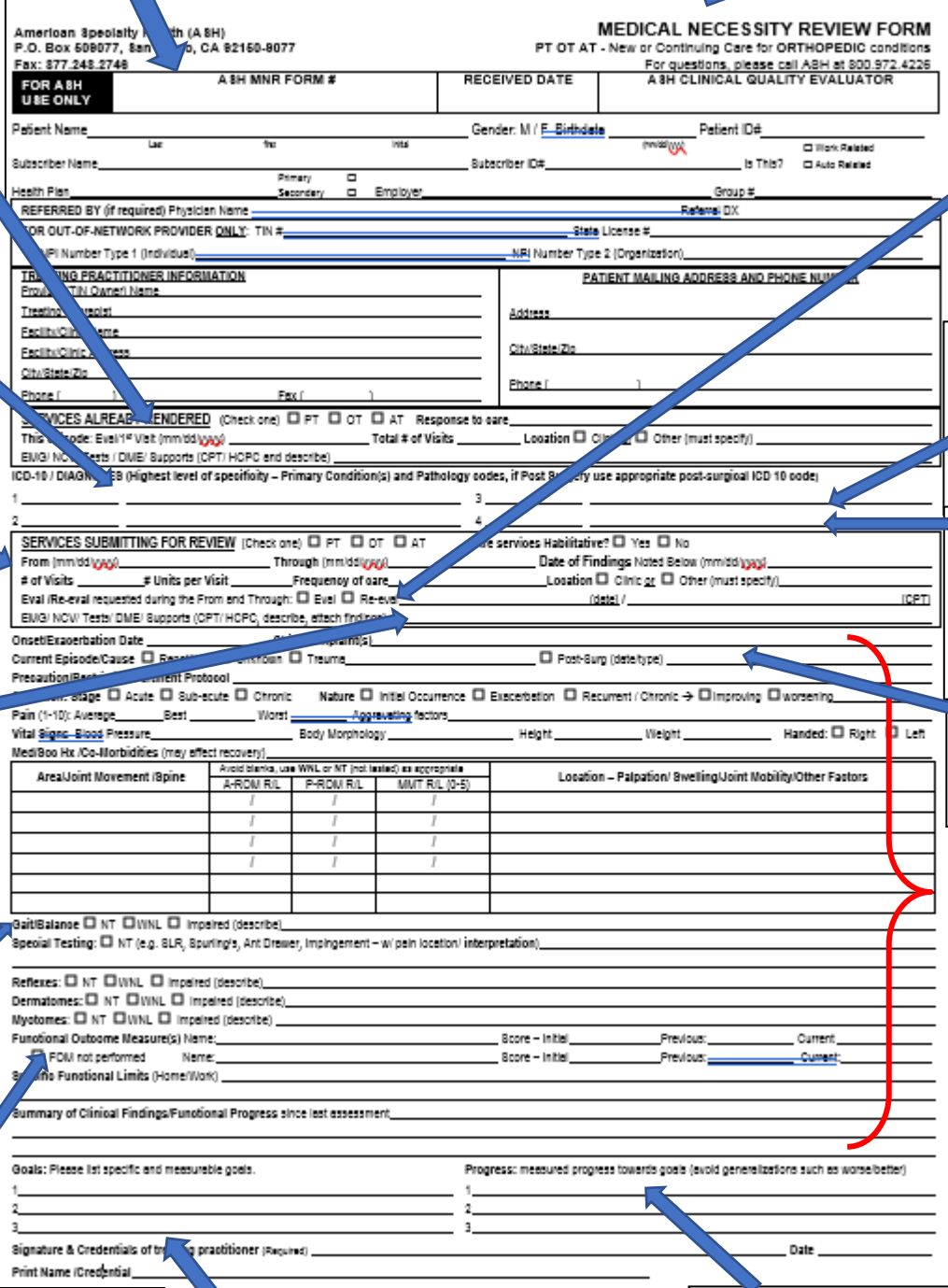
This is where treatment is occurring (e.g. clinic, home, gym, etc.)

Specify the type of surgery not just the body area

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

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.



MEDICAL NECESSITY REVIEW FORM

PT OT AT - New or Continuing Care for ORTHOPEDIC conditions

For questions, please call ASH at 800.972.4226

Fax: 877.248.2748

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

Patient Name | 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/Clinic Name

Facility/Clinic 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 ☐ Other (must specify)

EMG/ NCV/ Tests / DME/ Supports (CPT/ HCPC and describe)

ICD-10 / DIAGNOSES (Highest level of specificity – Primary Condition(s) and Pathology codes, if Post Surgery use appropriate post-surgical ICD 10 code)

1 | 2 | 3 | 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) / (CPT)

EMG/ NCV/ Tests/ DME/ Supports (CPT/ HCPC, describe, attach findings)

Onset/Exacerbation Date | Injury(s)

Current Episode/Cause ☐ Accident ☐ Caribbean ☐ Trauma ☐ Post-Surg (date/type)

Precaution/Restriction | Treatment Protocol

Stage ☐ Acute ☐ Sub-acute ☐ Chronic Nature ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic → ☐ Improving ☐ worsening

Pain (1-10): Average | Best | Worst | Aggravating factors

Vital Signs: Blood Pressure | Body Morphology | Height | Weight | Handed: ☐ Right ☐ Left

Med/Soc Hx /Co-Morbidities (may effect recovery)

Area/Joint Movement /Spine	Avoid blanks, use WNL or NT (not tested) as appropriate A-ROM R/L	P-ROM R/L	MMT R/L (0-5)	Location – Palpation/ Swelling/Joint Mobility/Other Factors
	/	/	/	
	/	/	/	
	/	/	/	
	/	/	/	

Gait/Balance ☐ NT ☐ WNL ☐ Impaired (describe)

Special Testing: ☐ NT (e.g. SLR, Spurling's, Ant Drawer, Impingement – w/ pain location/ interpretation)

Reflexes: ☐ NT ☐ WNL ☐ Impaired (describe)

Dermatomes: ☐ NT ☐ WNL ☐ Impaired (describe)

Myotomes: ☐ NT ☐ WNL ☐ Impaired (describe)

Functional Outcome Measure(s) Name: | Score – Initial | Previous: | Current

☐ FOM not performed Name: | Score – Initial | Previous: | Current:

Standing Functional Limits (Home/Work)

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

Signature & Credentials of treating practitioner (Required) | Date

Print Name /Credential