****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 Pediatric Conditions

Request eval/re-eval only if occurring during the dates requested AND submitting the findings from that exam and date performed

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 current skills being addressed as well as patient's current ability with that skill (e.g buttoning). These should support overall goals below (e.g. dressing).

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

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

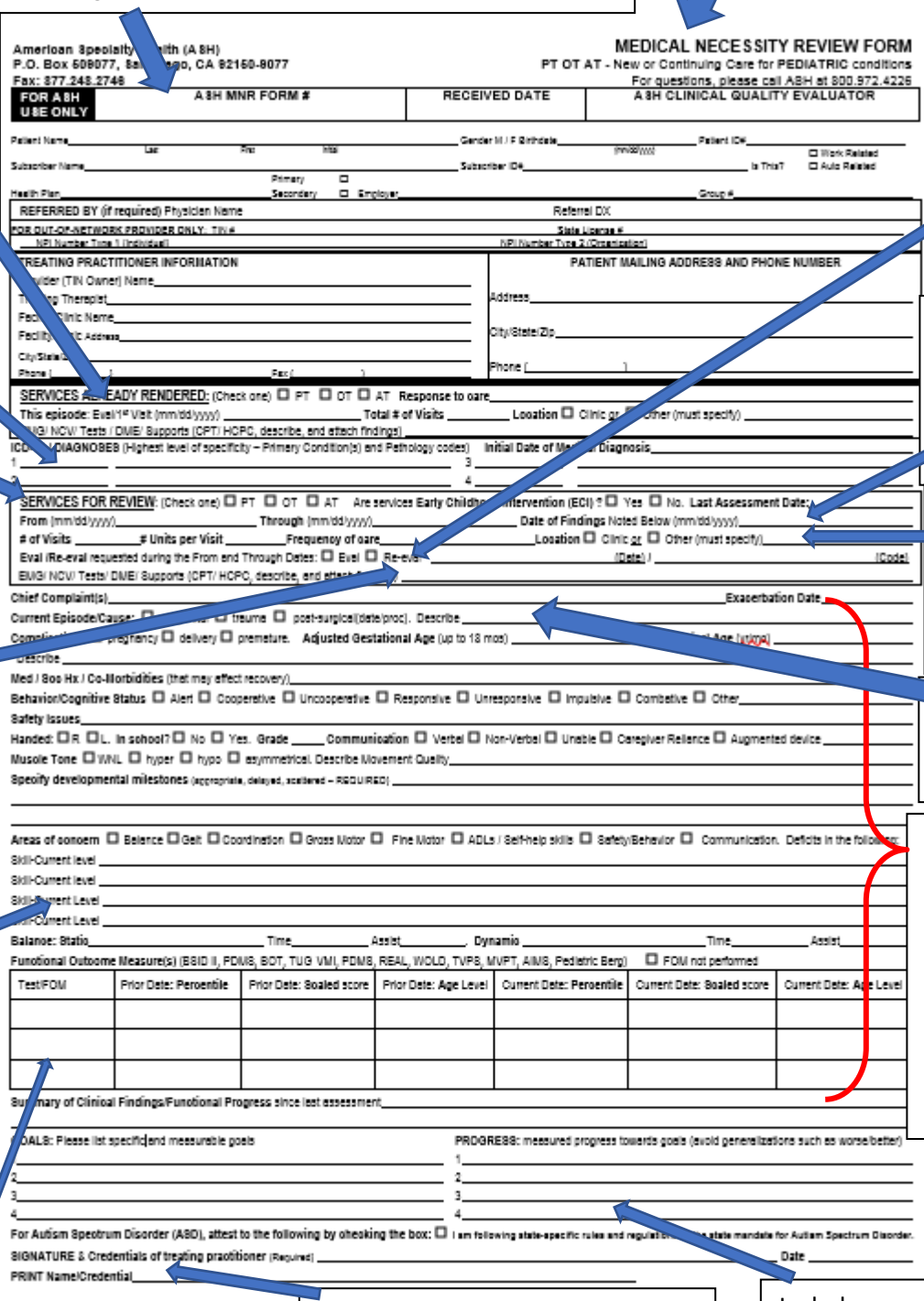
Specify the type of surgery not just the body area

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

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 (ASH)
P.O. Box 509077, San Diego, CA 92150-8077
Fax: 877.248.2748

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

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

Patient Name (Last, First, Init) Gender M / F Birthdate (mm/dd/yyyy) Patient ID# ☐ Work Related ☐ Auto Related
Subscriber Name Subscriber ID# Is This?
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 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) Initial Date of Medical Diagnosis
1 3
2 4

SERVICES FOR REVIEW: (Check one) ☐ PT ☐ OT ☐ AT Are services Early Childhood Intervention (ECI) ? ☐ Yes ☐ No. Last Assessment Date:
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 Dates: ☐ Eval ☐ Re-eval (Date) / (Code)
EMG/ NCV/ Tests/ DME/ Supports (CPT/ HCPC, describe, and attach findings)
Chief Complaint(s) Exacerbation Date
Current Episode/Cause: ☐ Trauma ☐ post-surgical(date/proc). Describe
Complications: ☐ pregnancy ☐ delivery ☐ premature. Adjusted Gestational Age (up to 18 mos) Age (yrs/mo)
Describe
Med / Soc Hx / Co-Morbidities (that may affect recovery)
Behavior/Cognitive Status ☐ Alert ☐ Cooperative ☐ Uncooperative ☐ Responsive ☐ Unresponsive ☐ Impulsive ☐ Combative ☐ Other
Safety Issues
Handed: ☐ R ☐ L. In school? ☐ No ☐ Yes. Grade Communication ☐ Verbal ☐ Non-Verbal ☐ Unable ☐ Caregiver Reliance ☐ Augmented device
Muscle Tone ☐ WNL ☐ hyper ☐ hypo ☐ asymmetrical. Describe Movement Quality
Specify developmental milestones (appropriate, delayed, sceldered – REQUIRED)

Areas of concern ☐ Balance ☐ Gait ☐ Coordination ☐ Gross Motor ☐ Fine Motor ☐ ADLs / Self-help skills ☐ Safety/Behavior ☐ Communication. Deficits in the following:
Skill-Current level
Skill-Current level
Skill-Current Level
Skill-Current Level
Balance: Static Time Assist Dynamic Time Assist
Functional Outcome Measure(s) (BSID II, PDMS, BOT, TUG VMI, PDMS, REAL, WOLD, TVPS, MVPT, AIMS, Pediatric Berg) ☐ FOM not performed

Test/FOM	Prior Date: Percentile	Prior Date: Scaled score	Prior Date: Age Level	Current Date: Percentile	Current Date: Scaled score	Current Date: Age Level

Summary of Clinical Findings/Functional Progress since last assessment

GOALS: Please list specific and measurable goals
1
2
3
4

PROGRESS: measured progress towards goals (avoid generalizations such as worse/better)
1
2
3
4

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