American Specialty Health Group

Use this form to ReOpen or Modify a MNR form that has already been submitted

Patient and Insured Demographics; name, gender, DOB, ID #, Health Plan

REOPEN / MODIFICATION

Rehabilitative Services

American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9
Fax: 877.248.2746

For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATION MANAGER

Patient Name_____ Patient ID #_____
Last First Initial

Patient Health Plan_____

Actual Treating Clinicians Name, Address, etc.

Provider (TIN Owner) Name_____
Treating Therapist_____
Facility/Clinic Name_____
Facility/Clinic Address_____
City/State/Zip_____
Phone (_____)_____ Fax (_____)_____

List the appropriate MNR Form Number for this submission.

ASH MNR FORM #

_____

List MNR Form # you want to Reopen or Modify

Provide additional clinical findings and rationale to be reviewed for medical necessity. You can attach additional findings i.e. Re-eval, Progress notes, or daily notes with findings to this for review.

☐ **REOPEN (Peer to Peer Communication)** This option should be chosen when submitting additional/revised information for clinical review in support of treatment/services **not approved** in the original submission or to correct errors in the previously submitted information.

Please clarify which treatment/services you are submitting for Reopen and provide rationale. You may attach the current MNR Form and additional information may also be attached or included below.

_____

_____

Reopen submissions for pre-service adverse determinations require prior patient consent in the following states: Ohio

☐ **In accordance with state regulatory requirements, I hereby attest to having the member's consent prior to submitting this reopen. [Note: When submitting a reopen for patients in the states listed above, this box must be checked for the reopen to be processed.]**

☐ **MODIFICATION** This option should **only** be chosen if you need to submit additional treatment/services beyond those previously submitted or change the approved dates of service.

Use this section of the form to make modifications to a MNR that has already been reviewed.

Check off the appropriate services needed to be considered during the same timeframe as the already approved services

OR

Check off the appropriate modification. If you need a date of service change, date extension or additional 1to 2 visits. If > than 2 visits, submit a new MNR with updated findings

☐ **Durable Medical Equipment**
HCPCS Code and Description_____
Rationale_____

_____

☐ **Add Additional Services Not Previously Submitted (e.g. EMG, NCV, FEES, MBS, other tests and measures)**

☐ **EMG** ☐ **NCV** ☐ **FEES** ☐ **MBS** ☐ **Other**

Provide rationale and additional clinical findings to support additional services.

CPT Code and Description_____
Rationale_____

_____

☐ **Dates of Service OR Visit Modification** Alteration to both DOS and visits cannot occur, if this is necessary then please submit an updated MNR Form in place of this modification.

☐ **Date Change**
The treatment period/dates should be: Start (mm/dd/yyyy)_____ **End (mm/dd/yyyy)**_____
Rationale_____

_____

☐ **Date Extension** (up to 30 days)
I am submitting for a date extension for this patient to _____ (mm/dd/yyyy).
Rationale_____

_____

☐ **Additional Office Visits (Maximum 2)**
I am submitting for Additional Number of Visits: # _____ **(maximum allowable is 2 in the already approved time frame, if > 2 visits needed please submit a new MNR)**. Discharge from care is expected at the completion of this time frame.
Rationale_____

_____

Request is MAX of 2 additional OVs. If more than 2 office visits needed and patient not ready for discharge, submit new MNR form with updated findings

Signature of treating practitioner (Required)_____ **Date**_____

The Reopen/Modification Form must be signed and dated by the treating clinician whose name appears above. Supervising therapist MUST co-sign for PTAs or COTAs.