OON Medical Records Cover Sheet (Please Use One Per Patient)

Practitioner Name:______________________________	TIN #______________________
Practitioner Address:	Practitioner Phone#:__________________ Practitioner FAX #:____________________ (Providing your FAX # will expedite the response to this request)
To: American Specialty Health	Date:
Fax: 877.248.2746	Pages:
Patient Name: Pt. Birth date:	Patient ID#: Gender: ☐ Male ☐ Female
Subscriber Name: Subscriber ID#:	Health Plan: Group #:

TREATMENT / SERVICES SUBMITTING FOR REVIEW

Diagnoses (ICD Code): 1.__________________ 3.__________________

(Symptom Description Required) 2.__________________ 4.__________________

Date Range: From: ____/____/_______ Through: ____/____/_______

#of Assessment Services: ☐ New Pt./ Initial ☐ Est. Pt./ Re-Assess.

#of Dates of Service: ☐

By submitting this *Cover Sheet*, I attest that the above dates and services are those I wish to have reviewed for medical necessity.

Please attach all relevant Assessment Forms, Clinical Notes or Reports that support the medical necessity of the submitted services.