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

Practitioner Name: _____

Practitioner Address:

Practitioner Phone#:_____

Practitioner FAX #:_____
(Providing your FAX # will expedite the response to this request)

*NPI # (Type 1-Ind)*_____ *NPI # (Type 2-Org)*_____

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 10 Code): 1._____ 3._____

2._____ 4._____

Date Range: From: ____/____/_____ Through: ____/____/_____

#of Assessment Services: ☐ New Pt./Initial

☐ Est. Pt./Re-Assessment.

Total #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.