American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9077
Fax: 877.248.2746

MEDICAL NECESSITY REVIEW FORM

PT OT AT-New or Continuing Care for **NEURO** 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 ______ Initial ◯ M ◯ F Gender ______ 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 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 code(s)

1 ______ ______ 3 ______ ______
2 ______ ______ 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) / ______ (code)
EMG/NCV/Tests and Measures/Other (Describe and Provide CPT codes, only if requesting) ______
DME / Supports (Describe and Provide HCPC Codes) ______

Date of Onset/Exacerbation ______ Location of Treatment ☐ Clinic ☐ Home
Chief Complaint(s) ______
Cause of Current Episode ☐ Traumatic ☐ Congenital ☐ Unknown ☐ Post-Surgical (Date/Type) ______ ☐ Other ______
Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic **Nature of Condition** ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic
Med/Soc Hx / Co-Morbidities (that may affect recovery) ______
Vital Signs: Blood Pressure ______ Body Morphology ______ Height ______ Weight ______ **Handed:** ☐ Right ☐ Left

Cognitive / Perceptual ☐ Intact ☐ Minimum ☐ Moderate Impairment ☐ Maximum Impairment
Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate ☐ Relies on primary care giver for communication needs
ROM / Strength ☐ WNL/WFL ☐ Impaired ______
Motor Skills ☐ WNL/WFL ☐ Impaired ______
Sensation/Tone ☐ WNL/WFL ☐ Impaired ______
Balance / Coordination ☐ WNL/WFL ☐ Impaired ______
Vestibular/visual testing ☐ WNL/WFL ☐ Impaired ______

Mobility **Bedmobility** ______ **Transfers** ______
☐ **Gait** ☐ **Wheelchair mobility** Assistance ______ Distance ______ Speed ______ Pattern ______
Activities of Daily Living ☐ Independent ☐ Deficits in the following:
Task ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Device ______
Task ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Device ______

GOALS 1 ______ PROGRESS TOWARDS GOALS 1 ______
2 ______ 2 ______
3 ______ 3 ______

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained (mm/dd/yyyy)	Current	Initial	List Date Obtained (mm/dd/yyyy)	Current
	10 meter walk			ABC	
	TUG score			Tinetti	
	Berg Balance score			DG	
	Dizziness Handicap Inventory			Other (Name/Score	

Add'l Findings to support diagnosis: ______
If you are treating this member for an Autism Spectrum Disorder (ASD), please attest to the following by checking the box below:
☐ **I am following state-specific rules and regulations of the state mandate for Autism Spectrum Disorder**

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

Practitioners are encouraged to submit additional information as necessary to support the intervention / care submitted