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 **ORTHOPEDIC** 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 _____ ◯ M ◯ F _____ _____
Last First Initial 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

Eval/1st visit date (mm/dd/yyyy) for this episode _____ **Response to Care** _____
Total number of visits rendered for this episode _____ EMG/NCV/Tests and Measures/Other (Describe and Provide CPT codes) _____
DME/Supports (Describe and Provide HCPC Codes) _____

ICD-10 / DIAGNOSES (highest level of specificity - Primary Condition(s) an (Pathology codes (If Post Surgery use appropriate post-surgical ICD-10 code)

1 _____ _____ 3 _____ _____
2 _____ _____ 4 _____ _____

SERVICES SUBMITTED FOR REVIEW **Are services Habilitative?** ☐ Yes ☐ No **Estimated Discharge Date** (Required)(mm/dd/yyyy) _____

This submission is for (Check only one. If both services are necessary, please fill out a separate form): ◯ PT ◯ OT ◯ AT

From (mm/dd/yyyy) _____ **Through** (mm/dd/yyyy) _____ **# of Visits** _____ Frequency/dosage of care _____

Date of Findings Noted Below (mm/dd/yyyy) _____

Evaluations/Reevaluations being requested during the From and Through dates: ☐ **Evaluation** _____ ☐ **Reevaluation** _____

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 _____ **Chief Complaint(s)** _____ Location of treatment _____

Cause of Current Episode ☐ Traumatic ☐ Repetitive ☐ Unknown ☐ MVA ☐ Post-Surgical (date/type) _____

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic ☐ Occupation _____

Nature of Condition ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

Pain (1-10): **Best-** _____ **Worst-** _____ **Aggravating factors-** _____

Vital Signs: Blood Pressure _____ Body Morphology _____ Height _____ Weight _____ **Handedness:** ☐ Right ☐ Left

Med/Soc Hx / Co-Morbidities (that may affect recovery)

Area/Joint Movement	A-ROM R/L	P-ROM R/L	Strength R/L (0-5)	Location - Palpation / Swelling	Joint Mobility
	/	/	/		
	/	/	/		
	/	/	/		
	/	/			
Spine: ☐ CS ☐ T/L					
Flexion / Extension	/	/			
R/L Rotation	/	/			
R/L Lateral Flexion	/	/			

Gait/Balance _____
Special Testing: (e.g., SLR, Ant Drawer, Impingement, Spurling's) _____

Reflexes: ☐ WNL ☐ Impaired _____ Myotomes: ☐ WNL ☐ Impaired _____
Dermatomes: ☐ WNL ☐ Impaired _____
Functional Outcome Measure(s) Name: _____ Score - Initial/Previous _____ Score - Current: _____
Additional outcome measure Name: _____ Score - Initial/Previous _____ Score - Current: _____
Goals (progress towards or new goals) _____
Add'l Findings/POC to support diagnosis: _____

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

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