American Specialty Health (ASH)
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MEDICAL NECESSITY REVIEW FORM

PT OT - New or Continuing Care for **PEDIATRIC** 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 **Location** ☐ Clinic or ☐ Other (must specify) ______

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)

1 ______ ______ 3 ______ ______
2 ______ ______ 4 ______ ______

SERVICES SUBMITTING FOR REVIEW This submission is for ◯ PT ◯ OT **Location** ☐ Clinic or ☐ Other (must specify) ______ Are services habilitative care? ☐ Yes ☐ No

From (mm/dd/yyyy) ______ **Through** (mm/dd/yyyy) ______ **# of Visits** ______ **frequency of care/dosage** ______

Estimated Discharge Date (Required)(mm/dd/yyyy) ______ Are services **Early Childhood Intervention (ECI)?** ☐ Yes ☐ No

Evaluations/Reevaluations being requested during the From and Through dates: ☐ **Evaluation** ______ ☐ **Re-evaluation** ______

EMG/NCV/Tests and Measures/Other (Describe and Provide CPT codes, only if requesting) ______

DME / Supports (Describe and Provide HCPC Codes, only if requesting) ______

Date of Onset/Medical Diagnosis ______ **Chief Complaint(s)** ______

Cause of Current Episode ☐ Traumatic ☐ Congenital ☐ Unknown ☐ Post-Surgical (Date/Type) ______

Estimated frequency of treatment (per week/month) ______ Estimated duration ______

Date of Last Assessment (mm/dd/yyyy) ______ Pregnancy & Birth History: Complications during ☐ Pregnancy ☐ Delivery ☐ Weeks of gestation at birth ______

Chronological Age ______ **Adjusted Gestational Age (up to 18 mos Chronological age)** ______

Behavior/Cognitive Status ☐ Alert ☐ Cooperative ☐ Responsive ☐ Confused ☐ Uncooperative ☐ Impulsive ☐ Combative ☐ Unresponsive

Communication ☐ Verbal ☐ Non-Verbal ☐ Unable to Communicate ☐ Relies on primary care giver for communication needs

Educational Level ______ Currently attending school? ☐ Yes ☐ No If yes, name of school ______

Developmental Milestones ______

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

Balance/Gait ______

Static ______ ☐ Good ☐ Fair ☐ Poor ☐ Zero Dynamic ______ ☐ Good ☐ Fair ☐ Poor ☐ Zero

Activities of Daily Living ☐ Independent ☐ Deficits in the following:

Task ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Device ______
Task ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Device ______

Muscle Tone ______ **Location** ______

Gross Motor Development ☐ Independent/Age Appropriate ☐ Deficits in the following:

Activity ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Goal: ______
Activity ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Goal: ______

Fine Motor Development ☐ Independent/Age Appropriate ☐ Deficits in the following:

Activity ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Goal: ______
Activity ______ ☐ Supervision ☐ MinA ☐ ModA ☐ MaxA ☐ Goal: ______

Self Care Activities: ☐ Normal/Age Appropriate ☐ Deficits in the following:

Activity ______ ☐ Good ☐ Fair ☐ Poor ☐ Zero ☐ Goal: ______
Activity ______ ☐ Good ☐ Fair ☐ Poor ☐ Zero ☐ Goal: ______

Summary of Clinical Findings/Functional Progress since last assessment

______

FOM - Functional Outcome Measures (List initial & current scores with dates)

Initial		Current	Initial		Current
	List Date Obtained (mm/dd/yyyy)			**List Date Obtained** (mm/dd/yyyy)	
	BSID III			**PDMS-2**	
	Other (Name/Score)			**BOT-2**	

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