Medical Records Cover Sheet **(One Per Patient)**

Treating DPM: _____

Provider Address: _____

Provider City/State/Zip: _____

Provider Phone#: _____

TIN # _____ FAX #: _____

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

To: American Specialty Health	Date:
Fax: 1.877.248.2746	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._____

2._____ 4._____

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

E&M Srv.: ☐99201 ☐99202 ☐99203 ☐99204 ☐99205

☐99211 x____ ☐99212 x____ ☐99213 x____ ☐99214 x____

Orthotics* / DME* / Supplies* (Codes): _____

PT (97000 series): Codes:_____ X ____; _____ X ____

Laboratory Services (codes):_____

X-rays/Imaging (CPT codes):_____

Surgery*/Debridement* Codes: _____ X ____; _____ X __

Injection Codes*: _____ X ____; _____ X ____ For Dx.#____

Casting*/Splinting*/Bracing*: Code _____X_____ For Dx.#____

Other Services (codes):_____

***These services may require Pre-Certification. Please call ASH for more information.**

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

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