Rehab OON Medical Records Cover Sheet

(Use One Per Patient)

All fields herein are required to be populated.

PROVIDER GROUP NAME (FACILITY):_____
BILLING TIN#:_____
TREATING PRACTITIONER NAME:_____
NPI # (Treating Practitioner):_____

Provider Address:_____
Provider City/State/Zip:_____
Provider Phone#:_____
Provider 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

Requesting: ☐ PT Services ☐ OT Services ☐ SLP Services ☐ AT Services (Choose only one)

Are services for Habilitative Care? ☐ Yes ☐ No

Initial Start of care for this condition:_____

Date of Evaluation or Reevaluation Findings: _____

# of Office visits already rendered:_____

Primary Diagnoses (ICD-10) (Highest level of specificity-Primary condition and Pathology codes)

1 _____ 2 _____ 3 _____ 4 _____

Date Range for Care: From: ___/___/___Through: ___/___/___

Services Requested Within above date range, please indicate:

PT and/or OT Evaluation or Re-Evaluation Services:

_____ Evaluation (ex: PT: 97161-97163, OT: 97165-97167) _____ Re-Evaluation (ex: PT: 97164, OT: 97168)

Total # of Rehab Service Visits during this duration: ____

EMG/NCV/FCE/Other Studies by CPT Code(s): _____

Durable Medical Equipment by HCPCS Code(s)_____

Additional/Updated Clinical Information not included in attached records: _____

_____

_____

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 (ASD).

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

Please attach the Clinical Information Summary Sheet or all relevant evaluation forms, progress notes or summary reports that support the medical necessity of the submitted rehabilitation services.

Do not submit daily notes without a summary of progress.