American Specialty Health (ASH)
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REOPEN / MODIFICATION

Rehabilitative Services
For questions, please call ASH at 800.972.4226

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATION MANAGER

Patient Name _____ Patient ID # _____
Last First Initial

Patient Health Plan _____

Provider (TIN Owner) Name _____
Treating Therapist _____
Facility/Clinic Name _____
Facility/Clinic Address _____
City/State/Zip _____
Phone _____ Fax _____

List the appropriate MNR Form Number for this submission

ASH MNR FORM #

_____

☐ **REOPEN (Peer to Peer Communication)** This option should be chosen when submitting additional/revised information for clinical review in support of treatment/services **not approved** in the original submission or to correct error in the previously submitted information.

Please clarify which treatment/services you are submitting for Reopen and provide rationale. You may attach the current MNR Form and additional information may also be attached or included below.

_____

Reopen submissions for pre-service adverse determinations require prior patient consent in the following states: Ohio

☐ **In accordance with state regulatory requirements, I hereby attest to having the member's consent prior to submitting this reopen, [Note? When submitting a reopen for patients in the states listed above, this box must be checked for the reopen to be processed.**

☐ **MODIFICATION** This option should **only** be chosen if you need to submit additional treatment/services beyond those previously submitted or change the approved dates of service.

☐ **Durable Medical Equipment**

HCPCS Code and Description _____
Rationale

_____

☐ **Add Additional Services Not Previously Submitted (e.g. EMG, NCV, FEES, MBS, other tests and measures)**

☐ **EMG** ☐ **NCV** ☐ **FEES** ☐ **MBS** ☐ **Other**

Provide rationale and additional clinical findings to support additional services.

CPT Code and Description _____
Rationale

_____

☐ **Dates of Service OR Visit Modification Alteration** to both DOS and visits cannot occur, if this is necessary then please submit an updated MNR Form in place of this modification.

☐ **Date Change**

The treatment/period/dates should be: Start (mm/dd/yyyy) _____ **End (mm/dd/yyyy)** _____
Rationale

_____

☐ **Date Extension** (up to 30 days)

I am submitting for a date extension for this patient to _____ (mm/dd/yyyy).
Rationale

_____

☐ **Additional Office Visits (Maximum 2)**

I am submitting for Additional Number of Visits: # _____ **(maximum allowable is 2 in the already approved time frame, if > 2 visits needed please submit a new MNR).** Discharge from care is expected at the completion of this time frame.
Rationale

_____

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