OON Medical Records Cover Sheet (Use One Per Patient)

PROVIDER GROUP NAME (FACILITY)_____
TREATING PRACTITIONER NAME_____
FACILITY TIN#_____

Provider Address_____
Provider City/State/Zip_____
Provider Phone#_____
Provider FAX #_____
(Providing your FAX # will expedite the response to this request)

*NPI # (Treating Practitioner)*_____

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

◯ PT Services ◯ OT Services ◯ ST Services ◯ AT Services (Choose only one)

Are services for Habilitative care? ◯ Yes ◯ No

Initial Start of care(mm/dd/yyyy) 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_____ 3_____

2_____ 4_____

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

Within above date range, please indicate:

Total #of Evaluation Services: ☐ Evaluation ☐ Re-Evaluation

Total #of Dates of Service / Office Visits: ☐

Imaging / Other Studies by CPT Code(s)_____

Durable Medical Equipment by HCPCS Code(s)_____

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 *OON Services 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, Clinical Notes or Reports that support the medical necessity of the submitted services.