American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

MEDICAL NECESSITY REVIEW FORM

For New Conditions or Continuing Care for Chiropractic

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_____ Sex: M / F Birthdate_____ Patient ID#_____
Last First Initial (mm/dd/yyyy)

☐ Work Related

Subscriber Name_____ Subscriber ID#_____ Is This? ☐ Auto Related

Primary ☐

Health Plan_____ Secondary ☐ Employer_____ Group #_____

Treating D.C._____
Address_____
City/State/Zip_____
Phone (_____) Fax: (_____)

PATIENT MAILING ADDRESS AND PHONE NUMBER

Address_____
City/State/Zip_____
Phone (_____)

DATES OF SERVICES RENDERED UNDER THE CLINICAL PERFORMANCE SYSTEM: (Required) ☐ No services rendered.

Exam/1st OV date (mm/dd/yyyy) current benefit year_____ **Response to care**_____
Last OV date rendered under CPS_____
Total number of OVs rendered under CPS_____
X-rays/Supports (CPT Codes)_____

ICD-9 (or ICD-10 when applicable) CODES / DIAGNOSES (must be to the highest level of specificity):

1_____ 3_____
2_____ 4_____

SERVICES SUBMITTING FOR REVIEW WITHIN THE FROM AND THROUGH DATES:

From_____ **Through**_____

Estimated Date of Release: (Required) _____
Exam (performed within above dates): Requesting: ☐ **New** ☐ **Established**
Date of Requested Exam: (mm/dd/yyyy) _____
Adj./Manip.: (Type)_____ ☐ **Requesting Extraspinal**
Therapy (Type)_____
EDX/Special/Prolonged Services/Other(by CPT)_____ _____
Supports and Appliances(by HCPCS)_____
X-ray Views (performed within above dates) (by CPT)_____

	# Office Visits	# Therapies
0 - 15 days		
16 - 30 days		
31 - 45 days		
46 - 60 days		
TOTAL		

IMAGING STUDIES OBTAINED: Date taken_____ Views _____ ☐ Taken at outside facility

Findings_____
Rationale for films_____

IS THIS SUBMISSION FOR MAINTENANCE / ELECTIVE CARE? ☐ Yes ☐ No

CHIEF COMPLAINT(s) with date(s) of onset: (mm/dd/yy) _____

MECH. OF INJURY/EXACERBATION _____

PERTINENT PAST HISTORY_____

Exam Date:_____ **VITAL SIGNS:** Height_____ Weight_____ Blood Pressure_____ Pulse_____ Temp_____ Resp_____

ROM: Cervical spine: ☐ N/A ☐ All WNL **Flexion** ___/60 or___% limited **Extension** ___/50 or___% limited

Lat flex Left ___/40 or___% limited Right ___/40 or___% limited **Rotation** Left ___/80 or___% limited Right ___/80 or___% limited

Lumbosacral spine: ☐ N/A ☐ All WNL **Flexion** ___/90 or___% limited **Extension** ___/30 or___% limited

Lat flex Left ___/20 or___% limited Right ___/20 or___% limited **Rotation** Left ___/30 or___% limited Right ___/30 or___% limited

Other_____

ORTHO: ☐ NA ☐ WNL **/NEURO:** ☐ NA ☐ WNL **/VASCULAR:** ☐ NA ☐ WNL (Please include location and intensity of findings.)

CHIROPRACTIC/PALPATORY ASSESSMENT_____

FUNCTIONAL ASSESSMENT/IMPROVEMENT_____

EXERCISE/HOME CARE_____

OUTCOME ASSESSMENTS: ☐ N/A **Date score obtained:** _____ ☐ Neck Disability score _____ ☐ Roland-Morris score _____
☐ Oswestry Low Back score _____ ☐ Perceived Improvement _____% ☐ Other (name) score _____

ADDITIONAL COMMENTS_____

Signature of treating D.C. (Required)_____ **Date**_____