AMERICAN SPECIALTY HEALTH NETWORKS, INC.

CHIROPRACTIC REQUIRED FORMS

APRIL 2008 NATIONAL VERSION 8.2

1. Clinical Treatment Form
2. Initial Health Status
3. Member Billing Acknowledgment
4. Member Plan Requirement Acknowledgment
5. Patient Progress
6. Provider Status Change Request
7. Reconsideration / Modification
8. Supportive Care

American Specialty Health Networks, Inc. (ASH Networks)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.304.2746

CLINICAL TREATMENT FORM

For New Conditions or Continuing Care (Chiropractic)
For questions, please call ASH Networks at 800.972.4226

FOR ASH NETWORKS USE ONLY	ASH NETWORKS TREATMENT FORM #	RECEIVED DATE	ASH NETWORKS CLINICAL SERVICES MANAGER

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

☐ Work Related

Subscriber Name: _____ Subscriber ID#: _____ Is This? ☐ Auto Related

Health Plan: _____ Primary ☐ 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 TREATMENT FORM WAIVER: (Required) ☐ No services rendered.

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

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

1. _____ _____ 3. _____ _____
2. _____ _____ 4. _____ _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: _____ **Through:** _____
Estimated Date of Release: (Required) _____
Exam (performed within above dates): ☐ **New** ☐ **Established**
Date of Exam Findings: (mm/dd/yyyy) _____
Adj./Manip.: (Type) _____
Therapy: (Type) _____
Supports/Appliances: _____
X-ray Views (performed within above dates): _____

	# 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: _____

CHIEF COMPLAINTS: **1** _____ **2** _____ **3** _____ **4** _____

DATE OF ONSET: (mm/dd/yyyy) _____ _____ _____ _____

MECH. OF INJURY/EXACERBATION: _____

PERTINENT PAST HISTORY: _____

VITAL SIGNS: Height _____ Weight _____ Blood Pressure _____ Temp _____

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/NEURO/VASCULAR/VBI: ☐ 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 _____

ADD'L. COMMENTS: _____

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

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INITIAL HEALTH STATUS

(Chiropractic) Fax: 877.304.2746

Patient Name: _____ Birthdate: _____ Sex: M / F

Address _____ City _____

State _____ Zip _____ Telephone (____) _____ Patient Primary Language _____

Occupation: _____ Employer: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

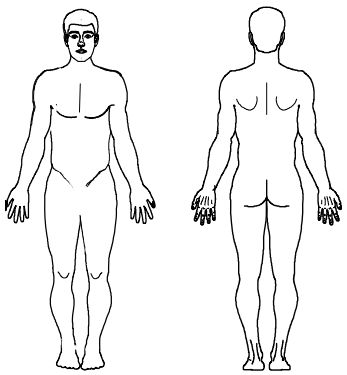
Subscriber Name: _____ Health Plan: _____

Subscriber ID #: _____ Group #: _____ Spouse Name: _____

Spouse Employer: _____ City: _____ State: _____ Zip: _____

Primary Care Physician Name: _____ PCP Phone: _____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began:

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present?

(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date) _____
- ☐ Corticosteroid Use (cortisone, prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain) _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain) _____
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries _____
- ☐ Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

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MEMBER BILLING ACKNOWLEDGMENT

(Chiropractic)

For questions, please call ASH Networks at 800.972.4226

I, _____, a member being treated by Dr. _____,
(Name of Patient/Member/Subscriber) (Chiropractor Name)

do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____.
(Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date:	Procedure:	Charge:
		$
		$
		$
		$
		$
		$

Separately list each date of service on which non-covered services will be rendered and have the Member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH Networks Member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the Member's payor. Non-covered services may also include services determined by ASH Networks to be maintenance-type services.

The ASH Networks Contracted Chiropractor may not bill the Member during the course of an ASH Networks approved treatment program unless there is a copayment, deductible, coinsurance, or the Member is receiving non-covered services.

The ASH Networks Contracted Chiropractor may not bill the Member for the difference between what the ASH Networks Contracted Chiropractor bills and what the ASH Networks Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Networks Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill Members for any services not reimbursed by ASH Networks. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the Member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my chiropractor, Dr. _____,
(Chiropractor Name)
to pay for these services myself.

Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

_____ _____
Member Signature Member Health Plan ID#:
(Guardian must sign for all members 17 years or younger)

_____ _____
Provider Signature Date

MEMBER PLAN REQUIREMENT ACKNOWLEDGMENT

(Chiropractic)

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Fax: 877.304.2746

For questions, please call ASH Networks at 800.972.4226

_____
ASH Networks Contracted Chiropractor

_____
Address

Plan Requirement Acknowledgment:

I, _____ acknowledge that I have been advised that my health plan
(Name of Patient/Member/Guardian)

_____ through my employer,
(Name of Health Plan)

_____ requires a Primary Care Physician referral for
(Name of Employer Group)

coverage of chiropractic services.

I understand that my plan requires a Primary Care Physician referral before I access Covered Services and if I have not already obtained a referral as prescribed under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for the charges listed below for services rendered. If the required referral condition is not met, I agree to pay in full for all services listed below within thirty (30) days of receiving a bill from the above chiropractor or health plan.

Date	Services Rendered	Charge
		$
		$
		$
		$
		$

_____ _____
Date Signature of Member (Or Subscriber)

_____ _____
Date Provider Signature

Note to Contracted Chiropractor's Office Personnel:

Please keep the original copy of the completed Member Plan Requirement Acknowledgment form in the member's file. If you need to submit this form to ASH Networks, please send it to ASH Networks at the address above. If you have any questions, call ASH Networks Provider Services at 800.972.4226.

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PATIENT PROGRESS

Patient completes this form. (Chiropractic)
For questions, please call ASH Networks at 800.972.4226

PLEASE PRINT LEGIBLY

Patient Name _____

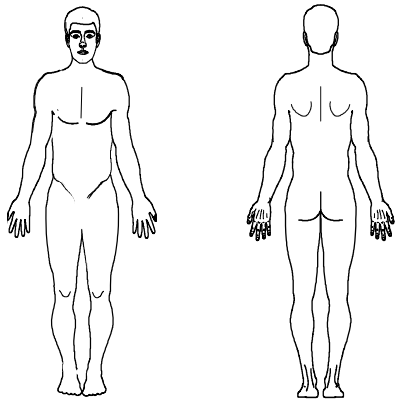
Please complete the following *three (3)* questions regarding how you feel today.

1. How do you feel today?

Current complaint:

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



2. Are you getting better?

Current Condition(s)/Complaint(s) **Rate your overall progress since starting care**

1. _____ _____ % **(0% = No improvement and 100% = Fully recovered)**

2. _____ _____ % **(0% = No improvement and 100% = Fully recovered)**

In the past week, on average how often have your symptoms been present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

0 1 2 3 4 5 6 7 8 9 10
No interference Unable to carry on any activities

3. Is there anything new?

Have you had any new complaints/conditions? ☐ No ☐ Yes

Have you had any re-injuries or events that have prolonged your recovery? ☐ No ☐ Yes

Explain: _____

_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____

American Specialty Health

PO Box 509001, San Diego, CA 92150-9001

ASH USE ONLY

Provider ID _____

Specialty _____

Effective Date _____

Rep Initial _____

PROVIDER STATUS CHANGE REQUEST

FOR QUESTIONS, CALL PROVIDER RELATIONS AT 800.972.4226, OPTION 4 ▪ FAX COMPLETED FORM TO 866.545.2746

REQUIRED IDENTIFYING INFORMATION (Please use information currently in ASH system)

CURRENT / OLD INFORMATION

Provider Name _____ **Specialty** _____
Last First MI Jr, Sr.

NPI # ☐ **Type 1 (Individual)** _____ **NPI #** ☐ **Type 2 (Organization)** _____

TIN (SSN or EIN) for this location now listed in ASH system _____

Clinic Name _____

Clinic Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Clinic Mailing Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Clinic Billing Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Clinic Telephone (_____) _____ **Clinic Fax** (_____) _____

Web Address _____ **Email Address** _____

TYPE OF CHANGE (For TIN related changes, remember to include updated W-9 Form)

EFFECTIVE DATE OF CHANGES CHECKED BELOW: month _____ day _____ year _____ Your Provider Services Agreement requires 60 days notice to effect a change. When 60 days notice is not given and/or when no effective date is stated on the line above, the effective date of change will be the date this Provider Status Change Request form is received by ASH.

CHECK ALL THAT APPLY. ENTER DETAILS OF THESE CHANGES ON THE APPROPRIATE LINE IN THE DETAILS SECTION:

☐ **Moving Clinic Stated Above**
Is this new address attached to or in a home? ☐ **Yes** ☐ **No**
(If yes, see ashcompanies.com for home office requirements)

☐ **Adding Clinic**
Is this new address attached to or in a home? ☐ **Yes** ☐ **No**
(If yes, see ashcompanies.com for home office requirements)

☐ **Closing Clinic**

☐ **Clinic/Business Name** _____

☐ **TIN Owner Name** _____

☐ **Provider Name** (Include copy of certificate or official record to effect this name change)

☐ **Telephone Number**

☐ **Fax Number**

☐ **Email Address**

☐ **Website Address**

☐ **Mailing Address**

☐ **Billing Address**

☐ **Taxpayer ID Number (SSN or EIN) Change ■ Attach updated W-9 Form for any TIN related change ■ Effective Date of New TIN** _____

Describe your relationship to the TIN owner reflected on the attached W-9 Form: ☐ Individual/Sole Proprietor ☐ Employee ☐ Owner/Co-Owner

New TIN _____

DETAILS OF CHANGE(S) (State details of all changes checked above)

Separate forms are needed for each office location AND provider affected by the change(s).

NEW INFORMATION

Provider Name _____ **Specialty** _____
Last First MI Jr, Sr.

Clinic Name _____

Clinic Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Is the new location address (check one): ☐ **Home** ☐ **Health Club/Gym** ☐ **Medical Building** ☐ **Office Building**
☐ **Shopping Center** ☐ **Other** _____

Clinic Mailing Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Clinic Billing Address _____ **Ste** _____ **City** _____ **St** _____ **Zip** _____

Clinic Telephone (_____) _____ **Clinic Fax** (_____) _____

Web Address _____ **Email Address** _____

Provider Signature (Required) _____ **Date** _____

The information stated herein serves to amend Attachment A of your in-force Provider Services Agreement

Comments _____

FAX COMPLETED FORM TO 866.545.2746 TOLL FREE (or 619.237.3857)

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RECONSIDERATION / MODIFICATION

(Chiropractic)

For questions, please call ASH Networks at 800.972.4226

FOR ASH NETWORKS USE ONLY	ASH NETWORKS TREATMENT FORM #	RECEIVED DATE	ASH NETWORKS CLINICAL SERVICES MANAGER

Patient Name _____ Patient ID # _____
Last First Initial

Patient Health Plan: _____

Treating D.C.: _____

Address: _____

City/State/Zip: _____

Phone: (_____) _____ Fax: (_____) _____

List the appropriate Treatment Form Number for this submission.

ASH NETWORKS TREATMENT FORM #

_____

RECONSIDERATION

(This option should **only** be chosen when submitting additional information to support treatment/services **not approved** in the original submission.)

☐ **Submitting Additional/Revised Information**

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

_____

_____

_____

Reconsideration 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 reconsideration. [Note: When submitting a Reconsideration for patients in the states listed above, this box must be checked for the reconsideration 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).

☐ **X-Rays and/or Radiological Consultation**

Views required: _____

Rationale for films/consult: _____

_____

☐ **Supports / Appliances**

Supports/Appliances required: _____

☐ **Dates of Service – Changes, Extensions** (up to 30 days)**, Reductions**

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

Rationale: _____

☐ **Additional Office Visits** (Up to 3)

Additional number of visits: #_____ Please provide current subjective and objective findings and rationale. Please note that submissions for additional office visits and/or therapies may not be submitted with a date extension.

_____

_____

☐ **Additional Therapies**

Number of submitted therapies: # _____ Please list the types of therapies (e.g., ultrasound) and rationale:

_____

☐ **Other**

Services/Clinical Rationale: _____

_____

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

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SUPPORTIVE CARE
(Chiropractic)

For questions, please call ASH Networks at 800.972.4226

FOR ASH NETWORKS USE ONLY	ASH NETWORKS TREATMENT FORM #	RECEIVED DATE	ASH NETWORKS CLINICAL SERVICES 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

Health Plan: _____ Primary ☐ Secondary ☐ Employer: _____ Group #: _____

Treating D.C.: _____	**PATIENT MAILING ADDRESS AND PHONE NUMBER**
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: (_____) _____ Fax: (_____) _____	Phone: (_____) _____

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

1. _____ _____ 3. _____ _____
2. _____ _____ 4. _____ _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: _____ **Through:** _____ **(UP TO 120 DAYS)**

☐ **Established Exam (performed within above dates)**

Date of Exam Findings: (mm/dd/yyyy) _____

Adj./Manip.: (Type) _____

Therapy: (Type) _____

Supports/Appliances: _____

X-ray Views (performed within above dates): _____

# Office Visits	# Therapies

(ALL SERVICES FOR SUPPORTIVE CARE SHOULD BE RENDERED ON PRN STATUS)

DATE OF MOST RECENT VISIT (mm/dd/yyyy): _____

BASIS FOR PERMANENCY:

Chief Complaints: _____

Current Exam Findings: _____

Imaging Studies Obtained (views taken): _____ Date taken: _____

Findings: _____

HAVE THERE BEEN ATTEMPTS TO WITHDRAW CARE? ☐ No ☐ Yes, please explain: _____

HAVE LIFESTYLE MODIFICATIONS BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, please explain: _____

HAS HOME-BASED SELF-CARE BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, please explain: _____

HAVE EXERCISE (ACTIVE REHABILITATION) INSTRUCTIONS BEEN PROVIDED? ☐ No ☐ Yes, explain: _____

HAS MANAGEMENT OR CO-MANAGEMENT BY PCP, PSYCHOLOGIST OR OTHER SPECIALIST(S) BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, explain: _____

OBJECTIVES OF CARE: _____

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