American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

MEDICAL NECESSITY REVIEW FORM

For New Conditions or Continuing Care for
Acupuncture and Oriental Medicine

FOR ASH USE ONLY	ASH MNR FORM #	RECEIVED DATE	ASH CLINICAL QUALITY EVALUATOR

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

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

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

PCP Name Dr Ayoub _____ Phone #(_____) _____

Clinic Name _____
Treating Practitioner _____
Address _____
City/State/Zip _____
Phone (_____) _____ Fax (_____) _____

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address _____
City/State/Zip _____
Phone (_____) _____

CONDITION	AND	ICD CODE
1.		
2.		
3.		
4.		

Eastern Diagnosis

Services Under The Clinical Performance System (CPS)

1st Office Visit date (mm/dd/yyyy) under CPS _____
Last Office Visit date rendered under CPS _____
Total number of Visits rendered under CPS _____

TREATMENT PLAN/SERVICES SUBMITTING FOR REVIEW

Evaluation & Management ☐ New Pt Exam ☐ Est Pt Exam **Date of Exam Findings for Chief Complaints Listed Below** (required)_____/_____/_____
Date: **From**_____/_____/_____**Through**_____/_____/_____**Total # Office Visits/Acupuncture**____**Total # of Therapies for Requested Dates***_____
***New Jersey Only* – Acu CPT units requested per date of service _____; *New Jersey Only* -Therapy units requested per date of service _____**
☐ Hot/Cold Packs (97010) ☐ Infrared (97026) ☐ Massage (97124) ☐ Therapeutic Exercise (97110) ☐ Ultrasound (97035)
☐ Other [Do not enter *acupuncture CPT codes (97810-97814) as they are part of OV/Acu above*] _____
Other Special Services / Lab / X-ray: List CPT code(s) _____
**Therapies may not be reimbursed if those services exceed the daily maximum allowable reimbursement. Please check applicable client summary for details.*

EXAM FINDINGS FOR DATE of EXAM LISTED ABOVE

CHIEF COMPLAINT(S) →	1 Need shoulder replacement	2	3
Location →			
Date of onset: →	Nov/24		
Pain Level (0-10) →	9		
Frequency (% of time) →	80% % of time present	_____ % of time present	_____ % of time present
Cause of Condition/Injury →	Overtime usage/Fall		
How long does relief last? →			
Observation (gait, swelling, color, shen, vitality, etc.) →			
Tenderness to palpation (0-4) →			
Range of Motion (% limited) →			

Response to most recent Treatment Plan: _____
Treatment Goals: _____
How will you measure progress toward these goals? _____

FUNCTIONAL OUTCOMES - Baseline and Changes

List the activities (sleep, work, recreation) you are monitoring for progress and any measurable results

Activity	Measurements (how much, how long, how far)	How has it changed?

***List Functional Outcome Tool Name, Body Area or Condition, Date and Score**

Functional Tool Name	Body Area/Condition	Date	Score

*Functional Outcome Tools that are either public domain or the copyright owner has made allowance for their general use are available through your ASHLink account login at www.ashlink.com on the Resources>Forms page

Changes in Pain Medication Use (e.g. name, frequency, amount, dosage) Advil
Being Cared for By a Medical Physician? ☐ No ☑ Yes; For What Condition(s)? Shoulder
If patient is under 3 years old, do you have a written referral for acupuncture on file from their medical physician for this condition? ☐ No ☐ Yes
If patient is between 3 and 11 years old, is their medical physician aware that they are receiving acupuncture for this condition? ☐ No ☐ Yes
(Required) Is this patient pregnant? ☐ No ☐ Yes; If Yes, # of weeks _____ Does patient have a medical practitioner for their pregnancy care? ☑ No ☐ Yes
Other Comments (e.g. Responses to Care, Barriers to Progress, Patient Health History) PCP phone: 800-443-0815

Vital Signs: Height 5 ft 2 in Weight 170 lbs **Blood Pressure** _____/_____ Temp _____ BMI _____ Tobacco Use ☐ Yes ☐ No
Tongue Signs _____ **Pulse Signs Rt** _____ **Lt** _____

Signature of Treating Practitioner _____ **Date** _____

PLEASE SUBMIT THIS FORM WITH INITIAL HEALTH STATUS (Initial Care) OR PATIENT PROGRESS FORM (ONGOING CARE)

If billing for Medicare Required Coverage of Chronic Lower Back Pain: ☐ I hereby attest this member meets the requirements for Chronic Low Back Pain as outlined by CMS Benefit Decision Memo (CAG 00452N).