American Specialty Health

Chiropractic
Required Forms

July 2012  ■  California Version 12.0

1. MNR Form
2. Reopen / Modification
3. Supportive Care
4. Initial Health Status
5. Patient Progress
6. Member Billing Acknowledgment
7. Practitioner Status Change Request
### 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

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**FOR ASH USE ONLY**

<table>
<thead>
<tr>
<th>ASH MNR FORM #</th>
<th>RECEIVED DATE</th>
<th>ASH CLINICAL QUALITY EVALUATION MANAGER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Sex: M / F</td>
<td>Birthdate (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Subscriber Name</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Employer</td>
<td>Group #</td>
</tr>
<tr>
<td>Treating D.C.</td>
<td>Address</td>
<td>City/State/Zip</td>
</tr>
<tr>
<td>Phone</td>
<td>Fax: ( )</td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT MAILING ADDRESS AND PHONE NUMBER**

<table>
<thead>
<tr>
<th>Address</th>
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<th>Phone ( )</th>
</tr>
</thead>
</table>

### DATES OF SERVICES RENDERED UNDER THE CLINICAL PERFORMANCE SYSTEM: (Required)

- No services rendered.
- Exam/1st OV date (mm/dd/yyyy) current benefit year
- Last OV date rendered under CPS
- Total number of OVs rendered under CPS
- X-rays/Supports (CPT Codes)

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

| 1          | 2          | 3          | 4          |

**TREATMENT/SERVICES SUBMITTING FOR REVIEW:**

<table>
<thead>
<tr>
<th>From</th>
<th>Through</th>
<th># Office Visits</th>
<th># Therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Date of Release: (Required)</td>
<td>0 - 15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam (performed within above dates):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>Established</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Exam Findings: (mm/dd/yyyy)</td>
<td>16 - 30 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adj./Manip.: (Type)</td>
<td>31 - 45 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy (Type)</td>
<td>46 - 60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports and Appliances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray Views (performed within above dates)</td>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IMAGING STUDIES OBTAINED:**

- Date taken: Views: [ ] Taken at outside facility

**Rationale for films:**

**IS THIS SUBMISSION FOR MAINTENANCE / ELECTIVE CARE?**

- Yes  
- No

**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

**ADDITIONAL COMMENTS**

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

Date
# REOPEN / MODIFICATION

**Chiropractic**

For questions, please call ASH at 800.972.4226

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<tr>
<th>Patient Name</th>
<th>Patient ID #</th>
<th>Patient Health Plan</th>
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<tbody>
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<td>Initial</td>
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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 errors 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.

- **X-Rays and/or Radiological Consultation**
  - Views required and Rationale for films/consult: 

- **Supports and Appliances**
  - Supports and Appliances required: 
  - Rationale: 

- **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 Rationale: 

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

DCReopenMod_032112.docx
**FOR ASH USE ONLY**

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**Patient Name**

**Sex:** M / F  **Birthdate:** ____________________  **Patient ID #:** ____________________

**Subscriber Name**

**Subscriber ID #:** ____________________  **Is This?:** ____________________  **Work Related:** ☐  **Auto Related:** ☐

**Health Plan**

**Primary:** ☐  **Secondary:** ☐  **Employer:** ____________________  **Group #:** ____________________

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**TREATMENT/SERVICES SUBMITTING FOR REVIEW:**

*From________ Through________ (UP TO 120 DAYS)*

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</tbody>
</table>

**TREATMENT**

- Established Exam (performed within above dates)
- Date of Exam Findings (mm/dd/yyyy)
- Adj./Manip. (Type)
- Therapy (Type)
- Supports and Appliances
- X-ray Views (performed within above dates): ____________________

**DATE OF MOST RECENT VISIT** (mm/dd/yyyy)

**BASIS FOR PERMANENCY:**

- Chief Complaints
- Current Exam Findings
- Imaging Studies Obtained (views 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:** ____________________
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

INITIAL HEALTH STATUS  
Chiropractic

Patient Name_________________  Birthdate_________________  Sex:  M / F

Address_________________  City_________________  State_________________  Zip_________________

State______Zip_______  Phone (_____  )_________________  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?

(Occasional)  ☐ 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

In general would you say your overall health right now is:

☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor

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:

☐ Alcohol/Drug Dependence

☐ Prostate Problems

☐ Recent Fever

☐ Menstrual Problems

☐ Diabetes

☐ Urinary Problems

☐ High Blood Pressure

☐ Currently Pregnant, # Weeks

☐ Stroke (Date)

☐ Abnormal Weight ☐ Gain  ☐ Loss

☐ Corticosteroid Use (Cortisone, Prednisone, etc.)

☐ Marked Morning Pain/Stiffness

☐ Taking Birth Control Pills

☐ Pain Unrelieved by Position or Rest

☐ Dizziness/Fainting

☐ Pain at Night

☐ Numbness in Groin/Buttocks

☐ Visual Disturbances

☐ Cancer/Tumor (Explain)_________________

☐ Surgeries_________________

☐ Other Health Problems (Explain)_________________

☐ Tobacco Use - Type_________________  Frequency_________________ /Day

☐ Osteoporosis

☐ Medications_________________

☐ Epilepsy/Seizures

☐ Other Health Problems (Explain)_________________

☐ Surgeries_________________

☐ 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 practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_________________  Date_________________
Patient Name ________________________________

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

1. How do you feel today?

Current complaint:

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

No Pain                                                                                  Unbearable Pain

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?
(Occasional) [ ] 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       [ ] 1       [ ] 2       [ ] 3       [ ] 4       [ ] 5       [ ] 6       [ ] 7       [ ] 8       [ ] 9       [ ] 10

Unable to carry on any activities

In general would you say your overall health right now is:
[ ] Excellent       [ ] Very Good       [ ] Good       [ ] Fair       [ ] Poor

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 practitioner immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature _____________________________ Date _____________________________
IMPERATIVELY NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>$</td>
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</tbody>
</table>

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 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 health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

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

The ASH Contracted Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH 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. 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 reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial arrangements with my chiropractor,

Dr. ____________________________, to pay for these services myself.

(Chiropractor Name)

Dated at ____________________________, this _______ day of ____________________________, 20________.

(city) (state) (date) (month) (year)

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date
# PRACTITIONER STATUS CHANGE REQUEST

**FOR QUESTIONS, CALL PRACTITIONER CONTRACT SERVICES AT 800.972.4226, OPTION 4 • FAX COMPLETED FORM TO 866.545.2746**

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

<table>
<thead>
<tr>
<th>Practitioner Name</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>M</td>
<td>Jr, Sr.</td>
</tr>
</tbody>
</table>

NPI # □ Type 1 (Individual) □ Type 2 (Organization)

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

Clinic Name

<table>
<thead>
<tr>
<th>Clinic Address</th>
<th>Ste</th>
<th>City</th>
<th>St</th>
<th>Zip+4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Mailing Address</td>
<td>Ste</td>
<td>City</td>
<td>St</td>
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</tr>
<tr>
<td>Clinic Billing Address</td>
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<td>St</td>
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</tbody>
</table>

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 Practitioner 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 Practitioner 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

- [ ] Taxpayer ID Number (SSN or EIN) Change □ Attach updated W-9 Form for any TIN related change □ Effective Date of New TIN

  - New TIN

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

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

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

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</tr>
</tbody>
</table>

Clinic Telephone (       )  Clinic Fax (       )

Web Address  Email Address

**Practitioner Signature** (Required) __________________________ Date __________

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

Comments __________________________

**FAX COMPLETED FORM TO 866.545.2746 TOLL FREE**