American Specialty Health (ASH)
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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 #_____ Employer_____

Health Plan_____ ☐ Primary ☐ Secondary Group #_____ Is this? ☐ Work Related ☐ Auto Related?

PCP Name_____ 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 Office Visits rendered under CPS_____

TREATMENT/SERVICES SUBMITTING FOR REVIEW

Evaluation & Management: ☐ New Pt Exam ☐ Est. Pt Exam **Date of Exam Findings (required):** ___ /___ /_____ **Estimated Release Date:** ____/___ /____

Date: From ____/____/_____ **Through** ____/____/_____ **Total # Office Visits/Acupuncture** _____ **Total # of Therapies for Requested Dates*** _____

***New Jersey Only* - Acupuncture CPT units requested per date of service** ____ ***New Jersey Only* -Therapy units requested per date of service** _____

☐ E-Stim-unattended (97014) ☐ E-Stim-manual (97032) ☐ Hot/Cold Packs (97010) ☐ Infrared (97026) ☐ Massage (97124)
☐ Therapeutic Exercise (97110) ☐ Ultrasound (97035) ☐ Other:_____

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.*

Treatment Goals:_____

How will you measure progress toward these goals? _____

Response to most recent Treatment Plan:_____

CHIEF COMPLAINT(S) →	**1**	**2**	**3**
Location →			
Date of onset: (mm/dd/yyyy) →	____/____/_____	____/____/_____	____/____/_____
Pain Level (0-10) →	Initial_____ This MNR_____	Initial_____ This MNR_____	Initial_____ This MNR_____
Frequency (% of Time) →	_____% of time present	_____% of time present	_____% of time present
Cause of Condition/Injury →			
How long does relief last? →			
Observation (gait, swelling, color, shen, vitality, etc.) →			
Tenderness to palpation (0-4) →			
Range of Motion (% limited) →			

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)_____

Being Cared for By a Medical Physician? ☐ No ☐ Yes; For What Condition(s)?_____

If patient is under 3 years old, do you have a written referral for acupuncture on file from their medical physician? ☐ 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, Pertinent Health History) _____

Vital Signs: Height _____ Weight _____ 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).**