

FOR ASH USE ONLY	ASH TREATMENT FORM #	RECEIVED DATE	ASH CLINICAL SERVICES MANAGER
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Patient Name _____ Sex: M / F Birthdate _____ Patient ID# _____
Last first Initial (mm/dd/yyyy)
Subscriber Name _____ Subscriber ID# _____ Is This? Work Related Auto Related
Health Plan _____ Primary Secondary Employer _____ Group # _____

REFERRED BY (if required) Physician Name _____ Referral DX _____

FOR OUT-OF-NETWORK PROVIDER ONLY: TIN # _____ State License # _____
NPI Number Type 1 (Individual) _____ NPI Number Type 2 (Organization) _____

TREATING PRACTITIONER INFORMATION	PATIENT MAILING ADDRESS AND PHONE NUMBER
Provider Group Name (clinic) _____	Address _____ City/State/Zip _____ Phone (_____) _____
Treating Therapist _____	
Address _____	
City/State/Zip _____	
Phone (_____) _____ Fax (_____) _____	

SERVICES ALREADY RENDERED (Check one) PT OT
Eval/1st Visit date (mm/dd/yyyy) for this episode _____ Response to care _____
Total number of Visits rendered for this episode _____
DME / Supports (Describe and Provide HCPC Codes) _____

ICD-9 / DIAGNOSES (Highest level of specificity – Primary Condition(s) and Pathology codes (If Post Surgery 1°=V57.1)
1 _____ 3 _____
2 _____ 4 _____

SERVICES THAT YOU ARE SUBMITTING FOR CONTINUED CARE
From (mm/dd/yyyy) _____ Through (mm/dd/yyyy) _____ # of Visits _____
Estimated Discharge Date (Required)(mm/dd/yyyy) _____ Date of Findings Noted Below (mm/dd/yyyy) _____
Evaluations/Reevaluations being requested during the From and Through dates: Evaluation 97001 / 97003 Re-evaluation 97002 / 97004
DME / Supports (Describe and Provide HCPC Codes) _____

Date of Onset/Exacerbation _____ **Chief Complaint(s)** _____
Cause of Current Episode Traumatic Repetitive Unknown Post-Surgical (date/type) _____
Stage of Condition Acute Sub-acute Chronic
Nature of Condition Initial Occurrence Exacerbation Recurrent / Chronic
Vital Signs Height _____ Weight _____ Blood Pressure _____

Area/Joint Movement	Active ROM R/L(Degrees)	Passive ROM R/L (Degrees)	Strength R/L (0-5)	Mobility (0-6, 3=NL)	End Feel	Pain Quality (Dull, Sharp, etc)
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			

Pertinent Evaluation Findings (Please include location and intensity of findings and note any significant progress) _____

Pt's Functional Limitations & Planned Interventions

Med/Soc Hx / Co-Morbidities (that may affect recovery) _____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	Current	Initial	Current
_____	_____	_____	_____
List Date Obtained (mm/dd/yyyy)		List Date Obtained (mm/dd/yyyy)	
_____	_____	_____	_____
Roland-Morris score	_____	Neck Index (NDI) score	_____
Oswestry score	_____	Optimal score	_____
Perceived Improvement (%)	_____	LEFS (LE) score	_____
Other: _____	_____	DASH (UE) score	_____

ADD'L. COMMENTS _____

Signature of treating practitioner (Required) _____ **Date** _____
Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Patient and Insured Demographics; name, gender, DOB, ID #, Health Plan

This form is for orthopedic conditions

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

CLINICAL TREATMENT FORM
 PTOT-New or Continuing Care for ORTHOPEDIC conditions
 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

Provider Group Name
 e.g. xyzabc PC or
 123abc Hospital

Specific response to previous treatment

Actual Treating Clinicians Name, Address, etc.

Based upon your clinical assessment, list acceptable diagnosis codes (see code sheet for commonly used therapy codes)

For the condition you are currently treating:
 -Enter the date of first visit, AND the -TOTAL number of visits you have already provided

Total number of visits you are submitting for during the from and through dates

Enter the Start and Thru date you are submitting for the new plan of care

Document the clinically relevant information about this patient that outlines the condition and supports your plan of care. Include results of orthopedic tests and measures performed

Provide the initial Functional Outcome Tool score utilized and any follow up score.

Patient Name _____ Sex: M / F Birthdate _____ Patient ID# _____
 Subscriber Name _____ Subscriber ID# _____ Is This? Work Related Auto Related
 Health Plan _____ Primary Secondary Employer _____ Group # _____
 REFERRED BY (If required) Physician Name _____ Referral DX _____
 FOR OUT-OF-NETWORK PROVIDER ONLY: TIN # _____ State License # _____
 NPI Number Type 1 (Individual) _____ NPI Number Type 2 (Organization) _____

TREATING PRACTITIONER INFORMATION | **PATIENT MAILING ADDRESS AND PHONE NUMBER**
 Provider Group Name (clinic) _____ Address _____
 Treating Therapist _____ City/State/Zip _____
 Address _____ City/State/Zip _____
 City/State/Zip _____ Phone (____) _____
 Phone (____) _____ Fax (____) _____

SERVICES ALREADY RENDERED (Check one) PT OT
 Eval/1st Visit date (mm/dd/yyyy) for this episode _____ Response to care _____
 Total number of Visits rendered for this episode _____
 DME / Supports (Describe and Provide HCPC Codes) _____
ICD-9 / DIAGNOSES (Highest level of specificity – Primary Condition(s) and Pathology codes (If Post Surgery 1^o=V57.1)
 1 _____ 3 _____
 2 _____ 4 _____

SERVICES THAT YOU ARE SUBMITTING FOR CONTINUED CARE
 From (mm/dd/yyyy) _____ Through (mm/dd/yyyy) _____ # of Visits _____
 Estimated Discharge Date (Required)(mm/dd/yyyy) _____ Date of Findings Noted Below (mm/dd/yyyy) _____
 Evaluations/Reevaluations being requested during the From and Through dates: Evaluation 97001 / 97003 Re-evaluation 97002 / 97004
 DME / Supports (Describe and Provide HCPC Codes) _____

Date of Onset/Exacerbation _____ Chief Complaint(s) _____
 Cause of Current Episode Traumatic Repetitive Unknown Post-Surgical (date/type) _____
 Stage of Condition Acute Sub-acute Chronic Exacerbation Recurrent / Chronic
 Nature of Condition Initial Occurrence Exacerbation Recurrent / Chronic

Vital Signs Height _____ Weight _____ Blood Pressure _____

Area/Joint Movement	Active ROM R/L(Degrees)	Passive ROM R/L (Degrees)	Strength R/L (0-5)	Mobility (0-6, 3=NL)	End Feel	Pain Quality (Dull, Sharp, etc)
	/	/	/	/	/	/
	/	/	/	/	/	/
	/	/	/	/	/	/
	/	/	/	/	/	/
	/	/	/	/	/	/

Pertinent Evaluation Findings (Please include location and intensity of findings and note any significant progress)

Pt's Functional Limitations & Planned Interventions

Med/Soc Hx / Co-Morbidities (that may affect recovery)

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained (mm/dd/yyyy)	Current	Initial	List Date Obtained (mm/dd/yyyy)	Current
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ADD'L COMMENTS

Signature of treating practitioner (Required) _____ Date _____
 Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

The Clinical Treatment Form must be signed and dated by the treating clinician whose name appears above as well

FOR ASH USE ONLY	ASH TREATMENT FORM # _____	RECEIVED DATE _____	ASH CLINICAL SERVICES MANAGER _____
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Patient Name _____ Sex M / F Birthdate _____ Patient ID# _____
Last First Initial (mm/dd/yyyy)

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

Health Plan _____ Primary Secondary Employer _____ Group # _____

REFERRED BY (if required) Physician Name _____ Referral DX _____

FOR OUT-OF-NETWORK PROVIDER ONLY: TIN # _____ State License # _____

NPI Number Type 1 (Individual) _____ NPI Number Type 2 (Organization) _____

TREATING PRACTITIONER INFORMATION	PATIENT MAILING ADDRESS AND PHONE NUMBER
Provider Group Name (clinic) _____	Address _____
Treating Therapist _____	
Address _____	
City/State/Zip _____	
Phone (____) _____ Fax (____) _____	City/State/Zip _____
	Phone (____) _____

SERVICES ALREADY RENDERED (Check one) PT OT

Eval/1st Visit date (mm/dd/yyyy) for this episode _____ Response to care _____

Total number of Visits rendered for this episode _____

DME / Supports (Describe and Provide HCPC Codes) _____

ICD-9 / DIAGNOSES (Highest level of specificity – Primary Condition(s) and Pathology codes (If Post Surgery 1°=V57.1))

1 _____ 3 _____

2 _____ 4 _____

SERVICES THAT YOU ARE SUBMITTING FOR CONTINUED CARE

From (mm/dd/yyyy) _____ Through (mm/dd/yyyy) _____ # of Visits _____

Estimated Discharge Date (Required)(mm/dd/yyyy) _____ Date of Findings Noted Below (mm/dd/yyyy) _____

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DME / Supports (Describe and Provide HCPC Codes) _____

Date of Onset / Exacerbation _____ **Chief Complaint(s)** _____

Cause of Current Episode Traumatic Congenital Unknown Post-Surgical (Date/Type) _____

Stage of Condition Acute Sub-Acute Chronic

Nature of Condition Initial Occurrence Exacerbation Recurrent / Chronic

Vital Signs Height _____ Weight _____ Blood Pressure _____

Cognitive / Perceptual Intact Minimum Moderate Impairment Maximum Impairment

Communication Verbal Non-Verbal Unable to Communicate Relies on primary care giver for communication needs

Mobility Ambulation / Gait Pattern _____

Wheelchair / Assistive devices _____

Transfers _____

Bed _____

Muscle Tone:

	Flaccid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Rigid
Location							
Head							
Trunk							
U. E.							
L. E.							

Balance / Coordination Normal Deficits in the following:

Static Position _____ Good Fair Poor Zero

Dynamic Position _____ Good Fair Poor Zero

Activities of Daily Living Independent Deficits in the following:

Task _____ CG/CS Min assist Mod assist Max assist Device _____

Task _____ CG/CS Min assist Mod assist Max assist Device _____

Sensation Intact Impaired Absent Location _____

Edema None Edema in the following location

+1 minimal (<.5cm) 2+ mild (.5cm) 3+ moderate (.5-1.5cm) +4 severe (>1.5cm)

Med/Soc Hx / Co-Morbidities (that may affect recovery) _____

OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	Current	Initial	Current
_____	_____	_____	_____
List Date Obtained (mm/dd/yyyy)	_____	List Date Obtained (mm/dd/yyyy)	_____
TUG score	_____	Peabody score	_____
Berg Balance score	_____	DASH score	_____
Other _____	_____	LEFS (LE) score	_____

ADD'L. COMMENTS _____

Signature of treating practitioner (Required) _____ **Date** _____

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

Patient and Insured Demographics; name, gender, DOB, ID #, Health Plan

This form is for neurological conditions

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

CLINICAL TREATMENT EPISODE
PTOT - New or Continuing Care for NEURO/PEDS/HOMECARE conditions
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

Provider Group Name
e.g. xyzabc PC or
123abc Hospital

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TREATING PRACTITIONER INFORMATION PATIENT MAILING ADDRESS AND PHONE NUMBER
Provider Group Name (clinic) _____ Address _____
Treating Therapist _____ City/State/Zip _____
Address _____ City/State/Zip _____
City/State/Zip _____ Phone () _____
Phone () _____ Fax () _____ Phone () _____

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Communication Verbal Non-Verbal Unable to Communicate Relies on primary care giver for communication needs
Mobility Ambulation / Gait Pattern _____
Wheelchair / Assistive devices _____
Transfers _____
Bed _____

Muscle Tone: Location
Flaccid Hypotonic Ataxic Athetoid Normal Spastic Rigid
Head

Trunk						
U. E.						
L. E.						

Foot

Balance / Coordination Normal Deficits in the following:
Static Position _____ Good Fair Poor Zero
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Activities of Daily Living Independent Deficits in the following:
Task _____ CG/CS Min assist Mod assist Max assist Device _____
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TUG score	_____	Peabody score	_____
Berg Balance score	_____	DASH score	_____
Other	_____	LEFS (LE) score	_____

ADDITIONAL COMMENTS _____

Signature of treating practitioner (Required) _____ Date _____
Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted

The Clinical Treatment Form must be signed and dated by the treating clinician whose name appears above as well