American Specialty Health (ASH)
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 at 800.972.4226

FOR ASH USE ONLY	**ASH TREATMENT FORM #**	**RECEIVED DATE**	**ASH 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

Primary ☐
Health Plan_____ 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

Provider Group Name (clinic)_____
Treating Therapist_____
Address_____
City/State/Zip_____
Phone (_____) Fax (_____)

PATIENT MAILING ADDRESS AND PHONE NUMBER

Address_____
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)_____
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

American Specialty Health Networks

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

This form is for orthopedic conditions

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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 FO	RECEIVED DATE	ASH NETWORKS CLINICAL SERVICES MANAGER

Patient Name_____ (Last / First / Initial) Sex: M / F Birthdate_____ (mm/dd/yyyy) Patient ID#_____
☐ Work Related
Subscriber Name_____ Subscriber ID#_____ Is This? ☐ 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)

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

Specific response to previous treatment

TREATING PRACTITIONER INFORMATION	PATIENT MAILING ADDRESS AND PHONE NUMBER
Provider Group Name (clinic)_____	
Treating Therapist_____	Address_____
Address_____	City/State/Zip_____
City/State/Zip_____	Phone (_____)_____
Phone (_____)_____ Fax (_____)_____	

Actual Treating Clinicians Name, Address, etc.

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

SERVICES ALREADY RENDERED (Check one) ☐ PT ☐ OT

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

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_____

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

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)

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

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)_____

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

Pt's Functional Limitations & Planned Interventions

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

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

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

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CLINICAL TREATMENT FORM

PTOT - New or Continuing Care for **NEURO/PEDS/HOMECARE** conditions
For questions, please call ASH at 800.972.4226

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

Patient Name_____ (Last / First / Initial) Sex M / F Birthdate_____ (mm/dd/yyyy) Patient ID#_____

☐ Work Related

Subscriber Name_____ Subscriber ID#_____ Is This? ☐ 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

Provider Group Name (clinic)_____
Treating Therapist_____
Address_____
City/State/Zip_____
Phone (_____)_____ Fax (_____)_____

PATIENT MAILING ADDRESS AND PHONE NUMBER

Address_____
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)_____

Evaluations/Re-evaluations 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 ☐ 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:

Location	Flaccid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Rigid
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**_____

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American Specialty Health Networks

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

This form is for neurological conditions

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Patient Name_____ (Last / First / Initial) Sex M / F Birthdate_____ (mm/dd/yyyy) Patient ID#_____

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

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

TREATING PRACTITIONER INFORMATION	PATIENT MAILING ADDRESS AND PHONE NUMBER
Provider Group Name (clinic)_____	
Actual Treating Clinicians Name, Address, etc. Treating Therapist_____	Address_____
Address_____	City/State/Zip_____
City/State/Zip_____	Phone (_____)_____
Phone (_____)_____ Fax (_____)_____	

Specific response to previous treatment

SERVICES ALREADY RENDERED (Check one) ☐ PT ☐ OT

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Location	Flaccid	Hypotonic	Ataxic	Athetoid	Normal	Spastic	Rigid
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	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**_____

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