PT/OT Notification Form

ACN Group, Inc. - Form NF-602

Instructions
Complete this form and submit via Web, mail, or fax to ACN Group within 3 days of the initial date of service. www.acnprovider.com

Patient s Name (Last, First, MI)

○ Female
○ Male

Patient's Date of Birth

Patients Address | City | State | Zip

○ Prim
○ Sec

Patient's Insurance ID# | Health Plan | Group Number

Referral Info (If required by health plan as stated on your Plan Summary.)

○ Yes ○ No

Referred | Referring Doctor | Date Referral Issued | Referral # | Condition referred for

Type of Service

○ PT only
○ OT only
○ Both PT and OT

Nature of Condition

① Initial onset (within last 3 months)
② Recurrent (multiple episodes of <3 months)
③ Chronic (continuous duration >3 months)

Functional Outcome Measure Score

Neck Index
DASH
_____ (other)
Back Index
LEFS
_____ (other)

The date you want this Notification to begin:

Anticipated Treatment Duration (weeks)

○ 4 ○ 6 ○ 8
○ 12 ○ 16 ○ 20

Cause of Current Episode

① Traumatic
② Unspecified
③ Repetitive
④ Post-surgical
⑤ Work related
⑥ Motor vehicle

Date of Surgery

Type of Surgery

① ACL Recon
② Rotator Cuff/Labral Repair
③ Tendon Repair
④ Spinal Fusion
⑤ Joint Replacement
⑥ Other _____

Patient Type

① New to Your Office
② Est'd, new to ACN Group
③ Est'd, new injury
④ Est'd, new episode
⑤ Est'd, continuing care

Anticipated Status After This Episode

① MTB, no residuals, discharged
② MTB, residuals, discharged
③ MTB, residuals, PRN/supportive care
④ Not at MTB, update tx goals/plan
⑤ Referred/transferred

Diagnosis

Clinical Primary

Check If Applicable - add comments to the right

○ There are significant co-morbidities/complicating factors that are delaying recovery. Describe _____

Clinic Name | Therapist Name and Specialty | Tax ID

Clinic Address | City | State | Zip

Clinic Phone Number

I declare that the above information is true and accurate to the best of my knowledge. It is my professional judgment that my treatment plan is not contraindicated for this patient. I have discussed the above condition, prognosis following this plan of care, and have established appropriate and realistic goals with the patient.

Therapist Signature | Date

ACN Group Use Only
rev 05/18/06

Effective Date | Reference Number | Overlap