ACUPUNCTURE

REQUIRED FORMS

1. Clinical Treatment Form
2. Informed Consent and Disclosure
3. Initial Health Status
4. Member Billing Acknowledgment
5. Member Grievance Form
6. Patient Progress
7. Provider Status Change Request
8. Reconsideration/Modification

February 2006
California
Version 6.0
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/248-2746

CLINICAL TREATMENT FORM
(Acupuncture)

Patient Name ___________________________ Sex M / F Birthdate __________ Patient ID # ___________________________
Subscriber Name ________________________ Primary □ Secondary □ Employer __________________ Group # __________
Health Plan — Primary □ Secondary □ Is this? □ Work Related? □ Auto Related?
PCP Referral required? □ Yes □ No If yes, referred by (Name of Doctor): ____________________________ Phone # __________

Clinic Name ____________________________ Patient mailing address and phone number
Treating Provider ________________________ Address ____________________________
Address ________________________________ Address ____________________________
City/State/Zip __________________________ City/State/Zip ______________________
Phone ( ) ______________________________ Fax ( ) ______________________

Dates of services rendered under the treatment form waiver: □ No services rendered
(Only Required for initial clinical treatment form submission)
Response to care: ____________________________

Exam/1 st OV date (mm/dd/yyyy) current benefit year: __________

# of Additional Office Visits: __________

Condition treated/western diagnosis ICD-9 Code Eastern diagnosis
1. ____________________________ 8 Principles: □ Yin □ Yang □ Interior □ Exterior
   □ Cold □ Heat □ Deficiency □ Excess
   □ Zang-Fu dysfunction:
   □ Qi dysfunction: □ Def. □ Sinking □ Stag □ Rebellious
   □ Blood dysfunction: □ Def. □ Stag □ Heat □ Cold
   □ Five Elements: __________________________________________
   □ Other: ____________________________

Treatment/services submitted:
Date: From ___________ Through: ___________ □ Acupuncture □ Home Care Advice □ Diet
   □ Electrostimulation □ GuaSha □ Herbs
   □ Moxibustion □ Acupressure/Tui-Na □ Cupping
   □ Cold/Heat Pad □ Infrared/Heat Lamp □ Qigong
   □ Nutritional Supplements □ Rehab Exercise □ Other: ____________________________

Estimated Date of Release: ___________

Patient’s current main complaint and mechanism of injury/onset: ____________________________

Health history: ____________________________

Outcome of previous treatment/services: ____________________________

Ongoing care (e.g., medications, therapy): ____________________________

Summary of objective findings (or □ page 2 attached) ____________________________

Vital signs: ____________________________

Current treatment goals/objectives: ____________________________

Please attach an updated “Initial Health Status” form or “Patient Progress” form for treatment/services approval.

Signature of provider of acupuncture services: ____________________________ Date: ____________________________

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American Specialty Health Plans of California, Inc.

CLINICAL TREATMENT FORM

Patient Name ____________________________ Occupation ____________________________ Exam date: ____________

Vital Signs: ____________________________ ____________________________ ____________________________ ____________________________

Pain Syndrome: Please indicate the pain locations on model's body and complete each of the findings:

1. Pain Location: ____________________________
   Pain Intensity: ____________________________
   Pain Frequency: ____________________________
   Range of Motion: ____________________________

2. Pain Location: ____________________________
   Pain Intensity: ____________________________
   Pain Frequency: ____________________________
   Range of Motion: ____________________________

3. Pain Location: ____________________________
   Pain Intensity: ____________________________
   Pain Frequency: ____________________________
   Range of Motion: ____________________________

4. Pain Location: ____________________________
   Pain Intensity: ____________________________
   Pain Frequency: ____________________________
   Range of Motion: ____________________________

General review and physical examination:

Facial Inspection
- Blue/cyanotic
- Red
- Yellow
- White/pale
- Dark/pigmented

Eyes/Ears/Nose/Throat
- Eyes/Ears/Nose/Throat
- Dry eyes
- Excessive tearing
- Yellow sclera
- Red sclera
- White discharge/sputum
- Yellow discharge/sputum
- Bloody discharge/sputum
- Enlarged tonsils

Fever and Chills
- Fever and Chills
- Simultaneous fever and chills
- Alternating fever and chills
- High fever
- Low fever
- Intermittent fever
- Fever in the evening
- Aversion to cold
- Aversion to heat

Perspiration
- No sweating
- Profuse sweating
- Spontaneous sweating

Abdomen
- Pregnancy
- Fleshy
- Belching
- Bloating
- Nausea/vomiting
- Watery regurgitation
- Acid regurgitation
- Pain with hunger
- Pain after eating
- Soft on palpation
- Rigidity on palpation
- Rebound pain

Sleeping
- Sleep
- Excessive dreaming
- Excessive sleep

Diet and Thirst
- Excessive appetite
- Poor appetite
- Hunger without desire to eat

Menstruation
- Early

Bowel Movements and Urination
- Constipation
- Diarrhea
- Burning anus
- Watery stool
- Loose stool
- Foul yellow stool
- Mucoid stool
- Bloody stool/tarry stool
- Frequent urination
- Scanty urine
- Dark yellow urine
- Cloudy urine
- Bloody urine
- Micturation pain
- Oribbling
- Burning urination
- Urinary incontinence

Laboratory Exam Findings: ____________________________ Date: ____________

Radiographic Exam Findings: ____________________________ Date: ____________

ADDITIONAL CLINICAL FINDINGS: (Orthopedic tests, range of motion, palpatory findings, neurological tests, systems review and observation, additional patient health history, patient progress, etc.):

OUTCOME ASSESSMENTS:
- N/A Date score obtained: ____________
- Neck Disability score ____________
- Roland-Morris score ____________
- Oswestry Low Back score ____________
- Perceived Improvement ____________% Other (name) score ____________

COMMENTS:

Signature of provider of acupuncture services: ____________________________ Date: ____________
INFORMED CONSENT:

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgment during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider’s use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.

- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.

- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow direct moxibustion where burning material contacts the skin.

- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.

- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.

- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.

- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.

- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

**Authorization for Release of Medical Information:** I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

**Treatment of Pediatric Patients <3 Years.** I understand that treatment of young children has some risk and should be coordinated with the child’s physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child’s medical doctor if/when necessary.

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Patient Name (please print)  
Primary Care Physician (or specialist) Name  
Primary Care Physician (or specialist) Telephone

Patient ID Number  
Patient Signature  
Date
American Specialty Health Plans of California, Inc. (ASH Plans)  
P.O. Box 509002, San Diego, CA  92150-9002  Fax: 877/248-2746

INITIAL HEALTH STATUS  
(Acupuncture)

For questions, please call ASH Plans at 888/226-8879

Patient Name ___________________________________________ Birthdate _____________ Sex  M / F

Address ___________________________ City ___________ State _______ Zip ________

Subscriber Name:______________________ Subscriber ID #: ___________ Group #: ______________________

Phone # (Home): ___________ Work #: ___________ Employer _______ Occupation ______

Primary Health Plan: _______________ Patient/Member ID #: __________________

2nd Health Plan: ___________ Primary Care Physician: ___________________ PCP phone #: ___________

Please describe your current health problem(s):

How and When it began:

If you are undergoing acupuncture treatments, describe your progress:

☐ Worsened  ☐ No change  ☐ 25% improved  ☐ 50% improved  ☐ 75% improved


No Pain    0         1        2         3         4         5         6         7         8        9         10    Unbearable Pain

How often are your symptoms present?  ☐ Constantly  ☐ Frequently  ☐ Intermittently  ☐ Occasionally

Describe your current health condition:  ☐ Good  ☐ Fair  ☐ Poor  ☐ Chronically ill

Can you perform your daily activities?  ☐ Yes, all activities  ☐ Some activities  ☐ Not at all

Are you currently under the care of a physician?  ☐ No  ☐ Yes, please explain ___________

What treatment have you been taking for the above condition(s)?  (Surgery, medications, injections, therapy, chiropractic, etc.) __________________________

Please check all of the following that apply to you:

☐ Alcohol/tobacco/drug dependence  ☐ Frequent urination  ☐ Sinusitis

☐ Abnormal menstruation  ☐ Headache  ☐ Stroke

☐ Allergies  ☐ Heart attack  ☐ Thyroid Disease

☐ Angina  ☐ Heartburn or indigestion  ☐ Medications __________

☐ Arthritis/rheumatoid arthritis  ☐ Hypertension  ☐ __________________________

☐ Artificial joints  ☐ Hospitalizations/surgical procedures __________

☐ Asthma  ☐ Kidney disease  ☐ Other: __________

☐ Blood disorder  ☐ Liver problems  If a family member has had any of the following, please mark the appropriate box and explain:

☐ Breast lumps  ☐ Pacemaker  ☐ Lupus

☐ Cancer/tumor  ☐ Painful menstruation  ☐ Cancer

☐ Convulsions/seizures  ☐ Palpitation/arrhythmia  ☐ Heart disease

☐ Diabetes  ☐ Peptic ulcer  ☐ Hypertension

☐ Diarrhea/constipation  ☐ PMS  ☐ Other: __________

☐ Excessive thirst  ☐ Pregnancy, months _________

☐ Fainting or dizziness  ☐ Prostate problems

☐ Fatigue  ☐ Rapid weight gain/loss

Comments: __________________________

I certify the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my ASH Plans Acupuncture Provider or an ASH Plans Clinical Services Manager may need to contact my PCP or treating physician if my condition needs to be co-managed. Therefore, I give my authorization to ASH Plans to contact my medical doctor if necessary.

Patient signature: ________________________ Date: __________________________

02/01/2006
I, ____________________________, a member being treated by ____________________________, 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 ________________________________. I understand and agree to be responsible to self-pay for the following services:

(Name of Health Plan)

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Charge</th>
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</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 Plans 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 payor. Non-covered services may also include services determined by ASH Plans to be maintenance-type services.

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

The ASH Plans Contracted Provider of Acupuncture Services may not bill the Member for the difference between what the ASH Plans Contracted Provider of Acupuncture Services bills and what the ASH Plans Contracted Provider of Acupuncture Services agreed contractually to accept as payment for services. This difference represents an amount the ASH Plans Contracted Provider of Acupuncture Services 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 Plans. 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 been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my acupuncture provider, ____________________________, to pay for these services myself.

(Acupuncture Provider Name)

Dated at ____________________________, California this ______ day of ____________________, 20_____.

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

Member Signature: ____________________________

Member Health Plan ID#

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

Provider Signature ____________________________

Date ____________________________
MEMBER GRIEVANCE FORM

Please return this completed form to initiate research into your grievance. You may return this form to the above address or FAX to 619-209-6237. Should you require assistance with completing this form or wish to file a grievance via telephone please contact American Specialty Health Plans of California, Inc. Member Services Department at 1-800-678-9133. If you think that waiting for an answer from your health plan will hurt your health, call and ask for an “Expedited Review.”

Date: __________________________
Your Name: ______________________ DOB: ______________
Address: _________________________
City: ___________________________ State: ___________ Zip: __________
Member Home Phone: (_____) Member Work Phone: (_____) 
Your Health Plan Name: ___________________________ Your Health Plan ID#: __________________________

**If Someone Other Than the Member Is Filing This Grievance, Please Provide the Following Information:**

Name: __________________________ Daytime Telephone #: (_____) ____________________
First and Last

Relationship to Member: __________________________
Address: __________________________
City: ___________________________ State: ___________ Zip: __________

If You Are Filing A Grievance Against A Provider, List The Provider’s Name Here: __________________________

DESCRIPTION OF Grievance: (Give dates, times, people’s name, places, etc. Use additional sheets if necessary) __________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

I hereby attest that the above information is true:

Signed __________________________ Date ______________

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-678-9133 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigation in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.”
Federal Employees: If you are a Federal Employee, you have additional rights through the Office of Personnel Management (OPM) instead of the DMHC. Please reference your Federal Employees Health Benefits (FEHB) Program Brochure, which states that you may ask OPM to review the denial after you ask your health plan to reconsider the initial denial or refusal. OPM will determine if your health plan correctly applied the terms of its contract when it denied your claim or request for service. Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division IV, P.O. Box 436, Washington, D.C. 20044.

Employees of Self-Insured Companies: You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your health plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer’s benefit plan administrator to determine if your employer’s benefit plan is governed by ERISA. Additionally, you and your health plan may have other voluntary alternative dispute resolution options, such as mediation.
Patient Name

Patient, please complete the following questions regarding how you feel today.

1. How do you feel today?
   
   Circle your pain level today
   
   No Pain                                                                                 Unbearable Pain
   0         1         2         3        4       5       6       7        8         9         10
   
   MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

   Circle average and the worst pain level over the past week
   
   No Pain                                                                                   Unbearable Pain
   0         1         2         3        4       5       6       7        8         9         10

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. ____________________________________________        ________ %  
   3. ____________________________________________        ________ %  

   In the past week, on average how often have your symptoms been present?
   (Intermittent) □ 0 – 25%  □ 26 – 50%  □ 51 – 75%  □ 76 – 100% (Constant)

   Currently, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?)
   
   No interference                                                                                 Unable to carry on any activities
   0         1         2         3        4       5       6       7        8         9         10

   Which type(s) of treatment appear to be most helpful to your condition(s)?
   □ Acupuncture treatment  □ Nutritional supplements  □ Rehab Exercise/Home Care
   □ Chinese herbs  □ Prescription Medication(s)  □ Spinal Adjustment/Manipulation
   □ Massage therapy  □ Physical therapy  □ Other: __________________________

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 the above information is complete and accurate to the best of my knowledge. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: ___________________________________________ Date: ____________________
# PROVIDER STATUS CHANGE REQUEST

Separate forms are needed for each office location being affected by the changes

Fax completed form to: 619/237-3857

## IDENTIFYING INFORMATION

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First:</th>
<th>Middle:</th>
<th>Jr., Sr.</th>
<th>Email Address:</th>
</tr>
</thead>
</table>

Any other name(s) by which you have been known: __________________________

Office location affected by the changes noted below:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

Office Telephone Number: (___________)  Specialty(s): __________________________

## TYPE OF CHANGE

- [ ] Address Change/Add/Close
- [ ] *Tax ID Information
- [ ] Other

Complete Section A  Complete Section B  Complete Section C

## SECTION A

- [ ] Moving
- [ ] Adding a location
- [ ] Closing a location

1. I will no longer be practicing at the above location effective: (date mm/dd/yy): ______________________

2. I will be moving to or begin practicing at the following location: __________________________

<table>
<thead>
<tr>
<th>First date of service (mm/dd/yy):</th>
<th>New Clinic Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Street Address:</th>
<th>City/State/Zip:</th>
</tr>
</thead>
<tbody>
<tr>
<td>___________________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

This will be my (circle one) Primary/Secondary location. Phone: (___________)  Fax: (___________)

<table>
<thead>
<tr>
<th>Mailing Address (if different from #2):</th>
<th>Billing Address (if different from #2):</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________</td>
<td>_____________________</td>
</tr>
</tbody>
</table>

## SECTION B

*ATTACH UPDATED W-9 FOR ANY TIN RELATED CHANGES

1. [ ] I will no longer be using Taxpayer ID Number: __________________________  OR  [ ] TIN Owner Name Change Only.

2. Effective Date: ______________________

3. This also affects ASH Provider(s) (list names): __________________________

4. Describe your relationship to the TIN owner reflected on the attached W-9:

<table>
<thead>
<tr>
<th>Self</th>
<th>Employee</th>
<th>Owner/Co-owner of group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

## SECTION C

Change type:

- [ ] Provider name  [ ] Mailing address  Old: __________________________

- [ ] Clinic/Business name  [ ] Billing address  New: __________________________

- [ ] Phone number  [ ] E-mail address  __________________________

- [ ] Fax number

The above serves to amend Attachment A of my in-force Provider Services Agreement.

Provider Signature: __________________________  Date: __________________________

Comments:__________________________________________________________
American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/248-2746

RECONSIDERATION/MODIFICATION
(Acupuncture)

For questions, please call ASH Plans at 888/226-8879

ASH PLANS TREATMENT FORM # RECEIVED DATE ASH PLANS CLINICAL SERVICES MANAGER

Patient Name

Patient ID# ____________________________

Patient Health Plan: ____________________________

Acupuncture Provider: ____________________________

Address: ____________________________

City/State/Zip: ____________________________

Phone: (____ ) ____________________________

Fax: (____ ) ____________________________

RECONSIDERATION (This option should only be chosen when submitting additional information to support treatment/services not approved in the original submission.)

☐ Submitting Additional/Revised Information:
   Please clarify which treatment/services you are submitting for reconsideration and provide rationale. You may attach the current Clinical Treatment Form. Additional information may also be attached or included below:
   ☐ Date: From ______________ Through ______________
   ☐ Total # of Office Visits/Acupuncture: ____________________________
   ☐ Established Exam: ____________________________
   ☐ Other: ____________________________

MODIFICATION (This option should only be chosen if you need to modify the treatment/services already approved or agreed upon in the original submission)

☐ 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 visits)
   Additional number of visits: ______________ Please provide current subjective and objective findings and rationale. Please note that modification for additional office visits may not be submitted with a date extension:

☐ Additional Examinations
   Date of Examination: ____________________________
   Clinical Rationale: ____________________________

☐ Other ____________________________
   Services/Clinical Rationale: ____________________________
   ____________________________
   ____________________________
   ____________________________

Signature of treating acupuncture provider: ____________________________ Date: ____________________________