American Specialty Health
Plans of California

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)

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

FOR ASH PLANS USE ONLY	ASH PLANS TREATMENT FORM #	RECEIVED DATE	ASH PLANS 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 # _____

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 _____
City/State/Zip _____	City/State/Zip _____
Phone (____) _____ Fax (____) _____	Phone (____) _____

DATES OF SERVICES RENDERED UNDER THE TREATMENT FORM WAIVER: ☐ No services rendered

(Only Required for initial clinical treatment form submission)

Exam/1st OV date (mm/dd/yyyy) current benefit year: _____ **Response to care:** _____

# of Additional Office Visits: _____

CONDITION TREATED/WESTERN DIAGNOSIS	ICD-9 Code
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

☐ New Condition ☐ Acute Condition ☐ Chronic Condition

EASTERN DIAGNOSIS

Eight 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: _____

Total # Office Visits/Acupuncture: _____

☐ Established Patient Exam: _____

Other Services: _____

Estimated Date of Release: _____

☐ 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: _____

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:** _____

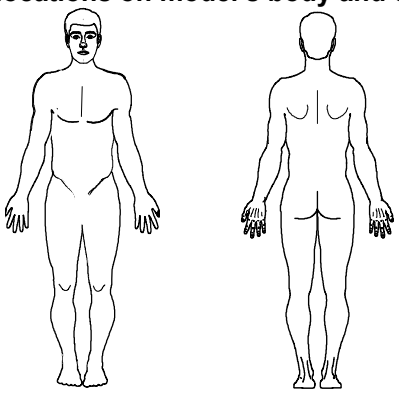
Patient Name _____ Occupation _____ Exam date: _____

Vital Signs: _____ (Height), _____ (Weight), _____ (Blood Pressure), _____ (Pulse Rate), _____ (Respiration), _____ (Temperature)

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: _____

***Please check the boxes where patient has abnormal findings (☒) or leave box blank if the finding is normal. Fill in blank lines or use "N/A" if not applicable.**

General review and physical examination:

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

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

Perspiration
- ☐ No sweating
- ☐ Profuse sweating
- ☐ Spontaneous sweating
- ☐ Night sweating
- ☐ Palm sweating

Chest/Breast
- ☐ Cough ☐ Wheezing
- ☐ Dyspnea
- ☐ Palpitation
- ☐ Abnormal breast secretions

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
- ☐ Poor sleep
- ☐ Excessive dreaming
- ☐ Excessive sleep

Diet and Thirst
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Hunger without desire to eat
- ☐ Inability to taste
- ☐ Sweet/sour/bitter taste
- ☐ Dire thirst and polydipsia
- ☐ Thirst without desire to drink
- ☐ Preference for hot water
- ☐ Preference for cold water

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
- ☐ Dribbling
- ☐ Burning urination
- ☐ Urinary incontinence

Menstruation
- ☐ Early
- ☐ Delayed
- ☐ Irregular
- ☐ Amenorrhea
- ☐ Dysmenorrhea
- ☐ PMS
- ☐ Hypomenorrhea
- ☐ (Metrorrhagia) Beng-Lou
- ☐ Dark red
- ☐ Brown red
- ☐ Excessive clots

Miscellaneous
- ☐ Low energy
- ☐ Low libido
- ☐ Infertility
- ☐ Impotence

Tongue Signs (Required)

Body _____

Coating _____

Pulse Signs (Required)

Right _____

Left _____

Laboratory Exam Findings: _____ **Date:** _____ *(please attach copy of report)*

Radiographic Exam Findings: _____ **Date:** _____ *(please attach copy of report)*

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:** _____

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INFORMED CONSENT AND DISCLOSURE

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

INFORMED CONSENT:

_____
Acupuncture Provider

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.

_____ Patient Name (please print)	_____ Patient ID Number
_____ Primary Care Physician (or specialist) Name	_____ Patient Signature
_____ Primary Care Physician (or specialist) Telephone	_____ Date

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INITIAL HEALTH STATUS

(Acupuncture)

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

Patient Name _____ Birthdate _____ Sex M / F
Last First

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 #: _____
(Required) (Required)

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

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: _____

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 <u>current</u> 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
- ☐ Abnormal menstruation
- ☐ Allergies
- ☐ Angina
- ☐ Arthritis/rheumatoid arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disorder
- ☐ Breast lumps
- ☐ Cancer/tumor
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Diarrhea/constipation
- ☐ Excessive thirst
- ☐ Fainting or dizziness
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headache
- ☐ Heart attack
- ☐ Heartburn or indigestion
- ☐ Hypertension
- ☐ Hospitalizations/surgical procedures_____
- ☐ Kidney disease
- ☐ Liver problems
- ☐ Pacemaker
- ☐ Painful menstruation
- ☐ Palpitation/arrhythmia
- ☐ Peptic ulcer
- ☐ PMS
- ☐ Pregnancy, months _____
- ☐ Prostate problems
- ☐ Rapid weight gain/loss
- ☐ Sinusitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ **Medications** _____
- ☐ Other:_____

If a family member has had any of the following, please mark the appropriate box and explain:

- ☐ Lupus
- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Other: _____

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:** _____

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MEMBER BILLING ACKNOWLEDGMENT

(Acupuncture)

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

I,_____, a member being treated by _____,
(Name of Patient/Member/Subscriber) (Acupuncture Provider Name)

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:

Date:	Procedure:	Charge:
		$
		$
		$
		$
		$
		$

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, _____,
(Acupuncture Provider Name)
to pay for these services myself.

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

American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

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.

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FAX: 877/248-2746

PATIENT PROGRESS

Patient completes this form. (Acupuncture)
For questions, please call ASH Plans at 888/226-8879

(PLEASE PRINT LEGIBLY)

Patient Name _____

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

1. How do you feel today?

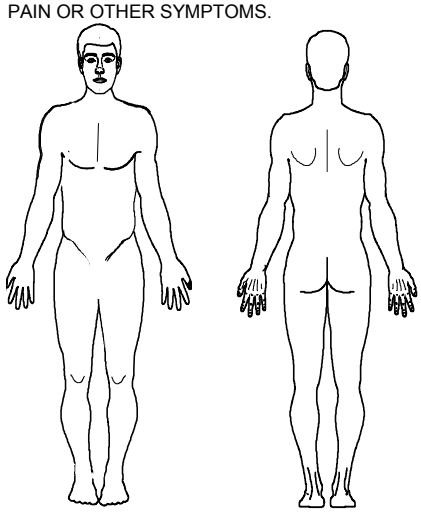
Circle your pain level today

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

Circle average and the worst pain level over the past week

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

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



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. _____	_____ %	(0% = No improvement and 100% = Fully recovered)
3. _____	_____ %	(0% = No improvement and 100% = Fully recovered)

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?)

0 1 2 3 4 5 6 7 8 9 10
No interference Unable to carry on any activities

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:** _____

American Specialty Health Plans of California

PO Box 509002, San Diego, CA 92150-9002

ASH PLANS USE ONLY

Provider ID: _____

Specialty: _____

Effective Date: _____

Rep Initial: _____

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

Last Name: First: Middle: Jr., Sr.

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

Office location affected by the changes noted below: City:

State: Zip:

Office Telephone Number: ( ) Specialty(s):

TYPE OF CHANGE

☐ Address Change/Add/Close *Complete Section A*

☐ *Tax ID Information *Complete Section B*

☐ Other *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: Is this office attached to or in a home? ☐ Yes ☐ No

First date of service (mm/dd/yy): _____ New Clinic Name: _____

New Street Address: _____

City/State/Zip: _____

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

Mailing Address (if different from #2): _____

Billing Address (if different from #2): _____

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:
   ☐ Self ☐ Employee ☐ Owner/Co-owner of group

SECTION C

Change type:

☐ Provider name ☐ Mailing address

☐ Clinic/Business name ☐ Billing address

☐ Phone number ☐ E-mail address

☐ Fax number

Old: _____

_____

New: _____

_____

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

Provider Signature: _____ **Date:** _____

Comments: _____

_____

_____

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Fax: 877/248-2746

RECONSIDERATION/MODIFICATION
(Acupuncture)

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

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

Patient Name _____ Patient ID# _____
Last First Initial

Patient Health Plan: _____

Acupuncture Provider: _____

Address: _____

City/State/Zip: _____

Phone: (_____) _____

Fax: (_____) _____

List the appropriate Treatment Form Number for this reconsideration/modification.

ASH PLANS TREATMENT FORM #

_____

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:** _____