



MESSAGE THERAPY

REQUIRED FORMS

1. Clinical Therapy Form
2. Initial Health Status
3. Member Billing Acknowledgment
4. Member Plan Requirement Acknowledgment
5. Patient Progress
6. Provider Status Change Request
7. Reconsideration/Modification

**January 2006
National
Version 6.0**

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

Provider of Massage Therapy Services: _____	PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: (____) _____ Fax: (____) _____	Phone: (____) _____

DATES OF SERVICES RENDERED UNDER THE THERAPY FORM WAIVER: (Required) No services rendered.
Date of Assessment/1st OV (mm/dd/yyyy) _____ **Response to care:** _____
Last OV date rendered under TFW _____
Total number of OVs rendered under TFW _____

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):
1. _____ 3. _____
2. _____ 4. _____

THERAPY/SERVICES SUBMITTING FOR REVIEW

From (mm/dd/yyyy): _____ Through (mm/dd/yyyy): _____	# Office Visits
Estimated Date of Release: (Required) _____	0 - 15 days _____
Assessment (performed within above dates): <input type="checkbox"/> Initial <input type="checkbox"/> Established	16 - 30 days _____
Date of Assessment Findings: (mm/dd/yyyy) _____	31 - 45 days _____
Massage Techniques to be used: _____	46 - 60 days _____
	TOTAL _____

REFERRING PROVIDER: _____
DESCRIPTION OF PROBLEM OR SYMPTOMS/FUNCTIONAL DISORDER: _____

DATE OF ONSET (mm/dd/yyyy): _____
CHIEF COMPLAINTS/CURRENT COMPLAINTS: (Symptoms, provocative/palliative factors, intensity/frequency/duration of symptoms) _____

MECHANISM OF INJURY/ONSET: _____
PAST HISTORY: _____

CLINICAL ASSESSMENT: (Posture, skin condition, tenderness, range-of-motion, muscle tone, etc.) _____

CURRENT THERAPY GOALS/OUTCOME MARKERS (For continuing care include progress toward goals; e.g., neck pain reduced from 8/10 to 3/10 scale): _____

EXERCISE/HOME CARE: _____
OUTCOME ASSESSMENTS: Date assessment score obtained: _____ Neck Disability score _____
 Oswestry LBP score _____ Headache Disability score _____ Other name and score _____

➤ PLEASE ATTACH UPDATED "INITIAL HEALTH STATUS" AND/OR "PATIENT PROGRESS" FORMS

Signature of massage therapy provider: _____ **Date:** _____
(Required)

Patient Name: _____ Birthdate: _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

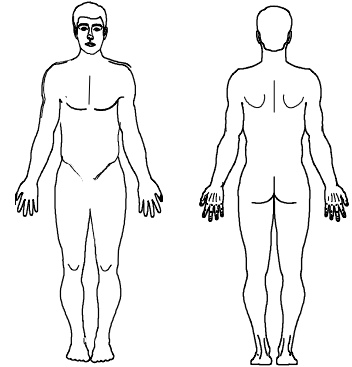
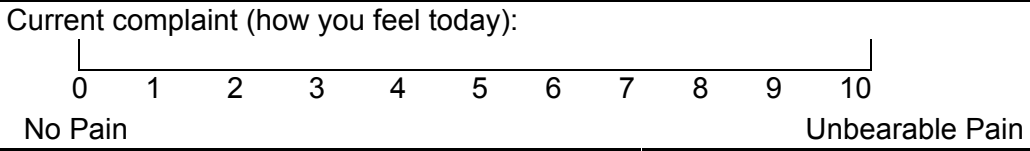
MARK AN X ON THE PICTURE BELOW WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain
 Other _____
Is this? Work Related Auto Related N/A

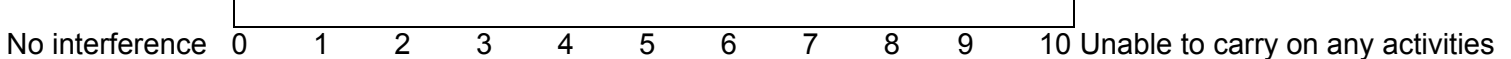
Date Problem Began: _____

How Problem Began:



How often are your symptoms present?
(Intermittent) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? No Yes

Date(s) taken: _____ **What areas were taken?** _____

Please check all of the following that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Stroke (date) _____ | <input type="checkbox"/> Currently Pregnant, # weeks _____ |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Marked Morning Pain/Stiffness |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Pain Unrelieved by Position or Rest |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Cancer/Tumor (explain) _____ | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Epilepsy/Seizures | _____ |
| <input type="checkbox"/> Other Health Problems (explain) _____ | <input type="checkbox"/> Medications: _____ |
| _____ | _____ |
| _____ | _____ |

Family History: Cancer Diabetes High Blood Pressure
 Heart Problems/Stroke Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. 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 rendered and I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my massage therapy provider or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my massage therapy provider and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

MEMBER BILLING ACKNOWLEDGMENT

(Massage Therapy)

For questions, please call ASH Networks at 877/288-2746

I, _____, a member being treated by _____,
(Name of Patient/Member/Subscriber) (Provider of Massage Therapy Services 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
(Name of Health Plan)

agree to be responsible to self-pay for the following services:

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 Networks 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 Networks to be maintenance-type services.

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

The ASH Networks Contracted Provider of Massage Therapy Services may not bill the Member for the difference between what the ASH Networks Contracted Provider's bills and what the ASH Networks Contracted Provider agreed contractually to accept as payment for services. This difference represents an amount the ASH Networks Contracted Provider 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 Networks. 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 therapy what portion of my care I will have to pay for, and agree to make financial arrangements with my Provider of Massage Therapy Services,

_____, to pay for these services myself.
(Provider of Massage Therapy Services Name)

Dated at _____, _____ this _____ day of _____, 20_____.
(city) (state) (date) (month) (year)

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

Member Health Plan ID#

Provider Signature

Date

American Specialty Health Networks, Inc. (ASH Networks)
P.O. Box 509001 San Diego, CA 92150-9001
Fax: 877/248-2746

MEMBER PLAN REQUIREMENT ACKNOWLEDGMENT

(Massage Therapy)

For questions, please call ASH Networks at 877/288-2746

ASH Networks Contracted Provider of Massage Therapy Services

Address

Plan Requirement Acknowledgment:

I, _____ acknowledge that I have been advised that my health plan
(Name of Patient/Member/Guardian)

_____ through my employer,
(Name of Health Plan)

_____ requires a referral for coverage of Massage
(Name of Employer Group)

Therapy services.

I understand that my plan requires a referral before I access Covered Services and if I have not already obtained a referral as prescribed under the terms of my employer's Medical and Hospital Subscriber Agreement or Insurance Policy, I am liable for the charges listed below for covered services rendered. If the required referral condition is not met, I agree to pay in full for all services listed below within thirty (30) days of receiving a bill from the above Provider of Massage Therapy Services or health plan.

Date	Services Rendered	Charge
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Date

Signature of Member (Or Subscriber)

Date

Provider Signature

Note to Contracted Provider of Massage Therapy Services' Office Personnel:

Please keep the original copy of the completed Member Plan Requirement Acknowledgment form in the member's file. If you need to submit this form to ASH Networks, please send it to ASH Networks at the address above. If you have any questions, call ASH Networks Provider Services at 877/288-2746.

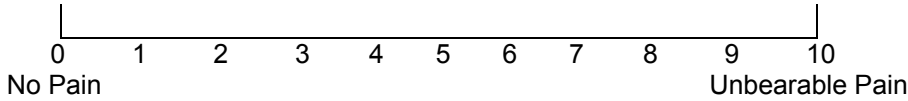
(PLEASE PRINT LEGIBLY)

Patient Name _____

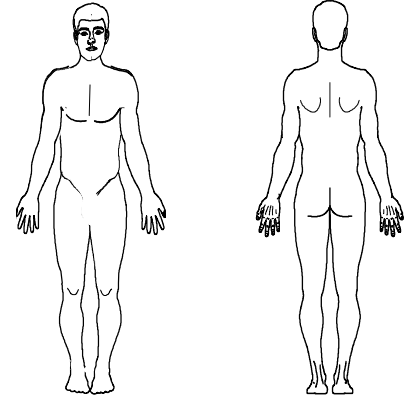
Please complete the following *three (3)* questions regarding how you feel today.

1. How do you feel today?

Current complaint: `



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

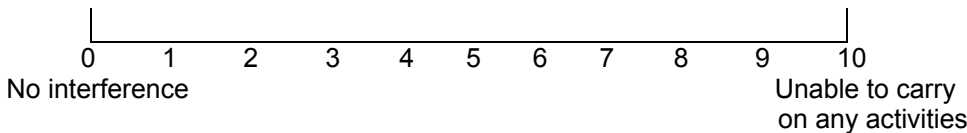
1. _____ % (0% = No improvement and 100% = Fully recovered)

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

In the past week, on average how often have your symptoms been present?

(Intermittent) 0 – 25% 26 – 50% 51 – 75% 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?



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 that 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: _____



PO Box 509001, San Diego, CA 92150-9001

ASH NETWORKS 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?
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 Old:
Clinic/Business name Billing address
Phone number E-mail address New:
Fax number

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

Provider Signature: Date:

Comments:

FOR ASH NETWORKS USE ONLY	ASH NETWORKS THERAPY FORM #	RECEIVED DATE	ASH NETWORKS CLINICAL SERVICES MANAGER
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Patient Name _____ Patient ID # _____
Last First Initial

Patient Health Plan: _____

Provider of MT Services: _____ Address: _____ City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____	List the appropriate Therapy Form Number for this request. <p style="text-align: center; font-weight: bold; font-size: 1.2em;">ASH NETWORKS THERAPY FORM #</p> _____
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RECONSIDERATION (This option should **only** be chosen when submitting additional information to support therapy/services **not approved** in the original submission.)

- Submitting Additional/Revised Information**
Please clarify which therapy/services you are submitting for reconsideration and provide rationale. You may attach the current Clinical Therapy Form and additional information may also be attached or included below.

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

- Dates of Service – Changes, Extensions (up to 30 days), Reductions**
 The therapy period/dates should be: Start (mm/dd/yyyy) _____ End (mm/dd/yyyy) _____
 Rationale: _____
- Additional Office Visits (Up to 3)**
 Additional number of visits: # _____ Please provide current subjective and objective findings and rationale. Please note that reconsideration for additional office visits **may not** be submitted with a date extension.

- Other**
 Services/Clinical Rationale: _____
-
-
-
-
-
-
-
-
-
-

Signature of Provider of Massage Therapy Services (Required) **Date**