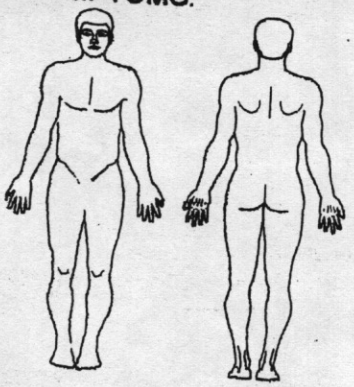
American Specialty Health Plans of California (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name Tiffany Anderson Birthdate 8-22-70 Sex M (F)
Address 1411 Iris Drive #7 City Lodi
State CA Zip 95242 Telephone (209) 3331032 Patient Primary Language English
Occupation Mosquito tech Employer S. J. County Work Phone 982-4675
Address 7759 S. airport City Stockton 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 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:

Current complaint (how you feel today):

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

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?

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

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:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date)
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain)
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain)

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries
☐ 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 doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature Date 3-21-07

IHS 2-13-06.doc

American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/427-4777

SUPPORTIVE CARE
(Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson (Last) Tiffany (First) (Initial) Sex: M / F Birthdate 9/22/70 (mm/dd/yyyy) Patient ID# 0007997964

Subscriber Name: _____ Subscriber ID#: _____ ☐ Work Related Is This? ☐ Auto Related

Health Plan: Kaiser Primary ☑ Secondary ☐ Employer: _____ Group #: 00000000303095

Treating D.C.: Dr. Gerard
Address: 515 S Fairmont Ave.
City/State/Zip: Lodi, Ca. 95240
Phone: 209 333-2401 Fax: 209 368-9005

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: 1416 Iris Drive #7
City/State/Zip: Lodi, Ca. 95240
Phone: 209 329-2339

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):

1. 729.2 Cervical Radiculitis
2. _____
3. _____
4. _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: 6/25/07 Through: 8-25-07 (UP TO 120 DAYS) 4 # Office Visits _____ # Therapies

(ALL SERVICES FOR SUPPORTIVE CARE SHOULD BE RENDERED ON PRN STATUS)

☒ Established Exam (performed within above dates)
Date of Exam Findings: (mm/dd/yyyy) 6/25/07.
Adj./Manip.: (Type) MA, COX
Therapy: (Type) _____
Supports/Appliances: _____
X-ray Views (performed within above dates): _____

DATE OF MOST RECENT VISIT (mm/dd/yyyy): 6/25/07

BASIS FOR PERMANENCY:

Chief Complaints: Frequent neck pain, intermittent b/l ant scap pain (4-5)

Current Exam Findings: Foram comp (+5) to both scaps, shoulder dep (+3) tenders to palp; C-T, Rom: Flex 55, Ex 30, LLF 32, RLF 25, LR 72, RR 65

Imaging Studies Obtained (views taken): _____ Date taken: _____

Findings: _____

HAVE THERE BEEN ATTEMPTS TO WITHDRAW CARE? ☐ No ☐ Yes, please explain: PT on PRN

HAVE LIFESTYLE MODIFICATIONS BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, please explain: pt is working on posture

HAS HOME-BASED SELF-CARE BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, please explain: Hot/cold

HAVE EXERCISE (ACTIVE REHABILITATION) INSTRUCTIONS BEEN PROVIDED? ☐ No ☐ Yes, explain: pt is actively exercising

HAS MANAGEMENT OR CO-MANAGEMENT BY PCP, PSYCHOLOGIST OR OTHER SPECIALIST(S) BEEN CONSIDERED AND ATTEMPTED? ☐ No ☐ Yes, explain: _____

OBJECTIVES OF CARE: Support, pain relief as needed

Signature of treating D.C. (Required): _____ **Date:** 7-24-07

American Specialty Health Plans of ifornia, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/427-4777

RECONSIDERATION / MODIFICATION (Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name Anderson (Last) Tiffany (First) (Initial) Patient ID # 007897964

Patient Health Plan: 0000000.30305

Treating D.C.: DR. gerard

Address: 515 S Fairmont ave #B

City/State/Zip: Lodi, Ca. 95240

Phone: (209) 333-2401 Fax: (209) 333-9202

List the appropriate Treatment Form Number for this request.

ASH PLANS TREATMENT FORM # 8108550.

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 and additional information may also be attached or included below.

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

☐ **X-Rays and/or Radiological Consultation**

Views required: _____

Rationale for films/consult: _____

☐ **Supports / Appliances**

Supports/Appliances required: _____

☐ **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)

Additional number of visits: # 2 Please provide current subjective and objective findings and rationale. Please note that reconsideration for additional office visits and/or therapies may not be submitted with a date extension.

Cervical and Thoracic spasm, Soto Hall (T4), Foramcorp (T4) to both hands, HR 42, ESR 22, WE 32, RLE 25, CR 105, RR 20

☐ **Additional Therapies**

Number of submitted therapies: # _____ Please list the types of therapies (e.g., ultrasound) and rationale:

☐ **Other**

Services/Clinical Rationale: P & Eval & Close up in late April

Signature of treating D.C. (Required): _____ Date: 5-4-07

American Specialty Health Plans of ifornia, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/427-4777

RECONSIDERATION / MODIFICATION (Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson (Last) Tiffany (First) (Initial) Patient ID #: 007897964

Patient Health Plan: 00000030305

Treating D.C.: DR. gerard
Address: 515 S Fairmont ave #B
City/State/Zip: Lodi, Ca. 95240
Phone: (209) 333-2401 Fax: (209) 333-9202

List the appropriate Treatment Form Number for this request.

ASH PLANS TREATMENT FORM # 8108550.

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 and additional information may also be attached or included below.

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

☐ **X-Rays and/or Radiological Consultation**

Views required: _____

Rationale for films/consult: _____

☐ **Supports / Appliances**

Supports/Appliances required: _____

☐ **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)

Additional number of visits: # 2 Please provide current subjective and objective findings and rationale. Please note that reconsideration for additional office visits and/or therapies may not be submitted with a date extension.

Cervical and Thoracic spasm, Soto Hall (4), Foamcorp (4) to both hands, HR 42, ESR 22, WR 22, RLE 25, CR 105, RMD

☐ **Additional Therapies**

Number of submitted therapies: # _____ Please list the types of therapies (e.g., ultrasound) and rationale:

☐ **Other**

Services/Clinical Rationale: P & Ln / a follow-up in late April

Signature of treating D.C. (Required): _____ **Date:** 5-4-07

American Specialty Health Plans of C rnia, Inc. (ASH Plans)
P.O. Box 509001, San Diego, CA 92150 -9001
Fax: 877/427-4777

CLINICAL TREATMENT FORM (Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson, Tiffany (Last, First, Initial) Sex: M / F Birthdate 8/22/70 (mm/dd/yyyy) Patient ID# CDO789 1969.

Subscriber Name: Subscriber ID#: ☐ Work Related Is This? ☐ Auto Related

Health Plan: Kaiser Primary ☑ Secondary ☐ Employer: Group #: CDDDD030305

Treating D.C.: Dr. James Gerard
Address: 515 S. Fairmont #B.
City/State/Zip: Lodi, Ca. 95240
Phone: (209) 333-2401 Fax: (209) 333-9202.

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: 1416 Iris dr #7
City/State/Zip: Lodi Ca. 95242
Phone: (209) 339-1032

DATES OF SERVICES RENDERED UNDER THE TREATMENT FORM WAIVER: (Required) ☐ No services rendered.
Exam/1st OV date (mm/dd/yyyy) current benefit year:
Last OV date under TFW: 9/13/06
Total # of OVs rendered under TFW: 5
X-rays/Supports (CPT Codes):
Response to care:

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):
1. 729.2 Cervical Radiculitis
2.
3.
4.

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: 3/21/06. Through: 5-21-07
Estimated Date of Release: (Required)
Exam (performed within above dates): ☐ New ☒ Established
Date of Exam Findings: (mm/dd/yyyy) 3/21/06.
Adj./Manip.: (Type) Mgn, Cox
Therapy: (Type) Stim
Supports/Appliances:
X-ray Views (performed within above dates):

	# Office Visits	# Therapies
0 - 15 days	4	4
16 - 30 days		
31 - 45 days		
46 - 60 days		
TOTAL	4	4

IMAGING STUDIES: Date taken: Views ☐ Taken at outside facility
Findings:
Rationale for films:

CHIEF COMPLAINTS: 1 neck pain 2 rad to both SUPRASCAPS 4
DATE OF ONSET: (mm/dd/yyyy) 3-20-07
MECH. OF INJURY/EXACERBATION: Overexertion, lifting
PERTINENT PAST HISTORY: Chronic neck

VITAL SIGNS: Height 5'3½ Weight 143 Blood Pressure 87/68 Temp
ROM: Cervical spine: ☐ N/A ☐ All WNL Flexion 50/60 or ___% limited Extension 25/50 or ___% limited
Lat flex Left 30/40 or ___% limited Right 30/40 or ___% limited Rotation Left 70/80 or ___% limited Right 65/80 or ___% limited
Lumbosacral spine: ☐ N/A ☐ All WNL Flexion ___/90 or ___% limited Extension ___/30 or ___% limited
Lat flex Left ___/20 or ___% limited Right ___/20 or ___% limited Rotation Left ___/30 or ___% limited Right ___/30 or ___% limited
Other:

ORTHO/NEURO/VASCULAR/VBI: ☐ N/A ☐ All WNL (Please include location and intensity of findings.)
Forem carp tx to both scaps
bilat shoulder dep

CHIROPRACTIC/PALPATORY ASSESSMENT: tenderness bilat C-T

FUNCTIONAL ASSESSMENT/IMPROVEMENT:

EXERCISE/HOME CARE:

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

ADD'L. COMMENTS:

Signature of treating D.C. (Required): Date: 4-25-07

American Specialty Health Plans of Ca[illegible]nia, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 92150-9002
Fax: 877/427-4777

RECON[illegible]DERATION / MODIFICATION
(Chiropractic)
For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson. Tiffany (Last / First / Initial) Patient ID #: 00789796 4-01

Patient Health Plan: Kaiser.

Treating D.C.: DR. James gerard
Address: 515 S. Fairmont ave #B
City/State/Zip: Lodi, Ca. 95240
Phone: (209) 333-2401 Fax: 209 ,333-2491

List the appropriate Treatment Form Number for this request.
ASH PLANS TREATMENT FORM #
8202780

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 and additional information may also be attached or included below.

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

☐ **X-Rays and/or Radiological Consultation**
Views required:
Rationale for films/consult:

☐ **Supports / Appliances**
Supports/Appliances required:

☐ **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)
Additional number of visits: # 3 Please provide current subjective and objective findings and rationale. Please note that reconsideration for additional office visits and/or therapies may not be submitted with a date extension.
intermittent neck and upper back pain (+4) restricted ROM, tenderness p/p C-T, Foramen comp to both (+4) shoulders and shoulder dep. (+3) bilat

☐ **Additional Therapies**
Number of submitted therapies: # Please list the types of therapies (e.g., ultrasound) and rationale:

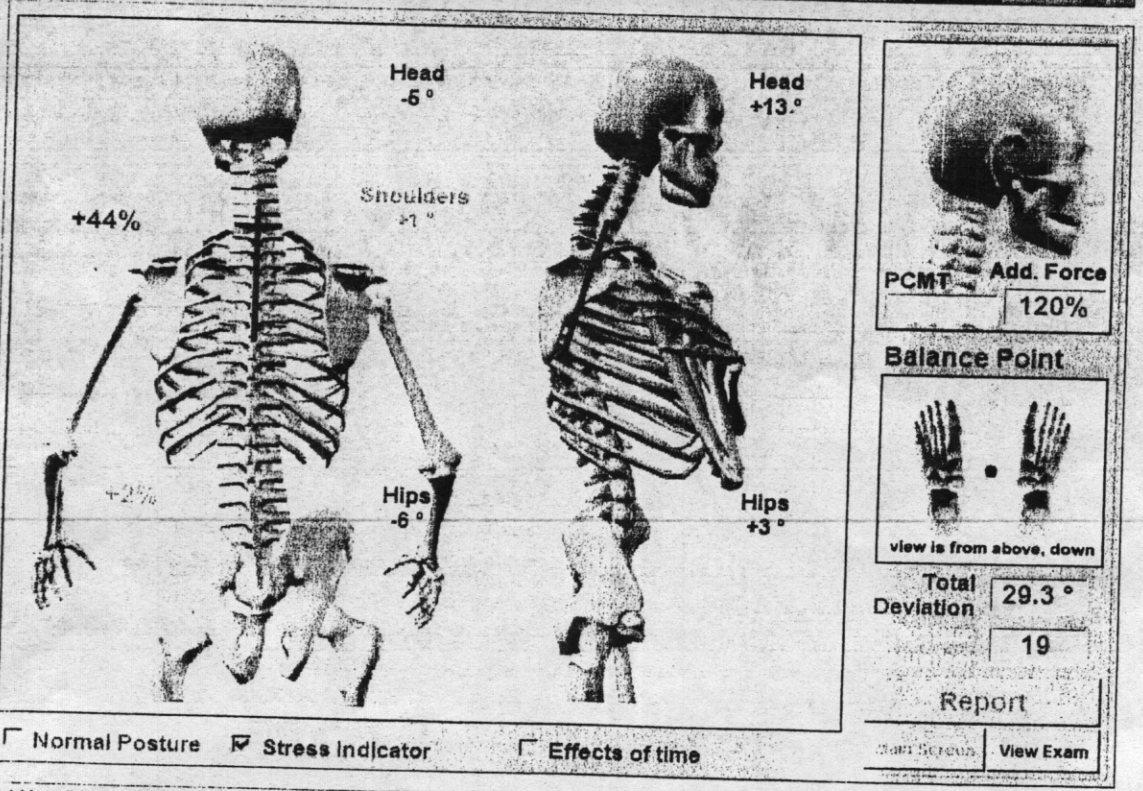
☐ **Other**
Services/Clinical Rationale: By the time I got around to MS Andersons last report (7-24-07) she had used 20 of her visits. She had a flare up around 5-1-07 and has been in for weekly tx.

Signature of treating D.C. (Required): Date: 8-21-07

Tiffany Anderson: 03/21/07 16:41

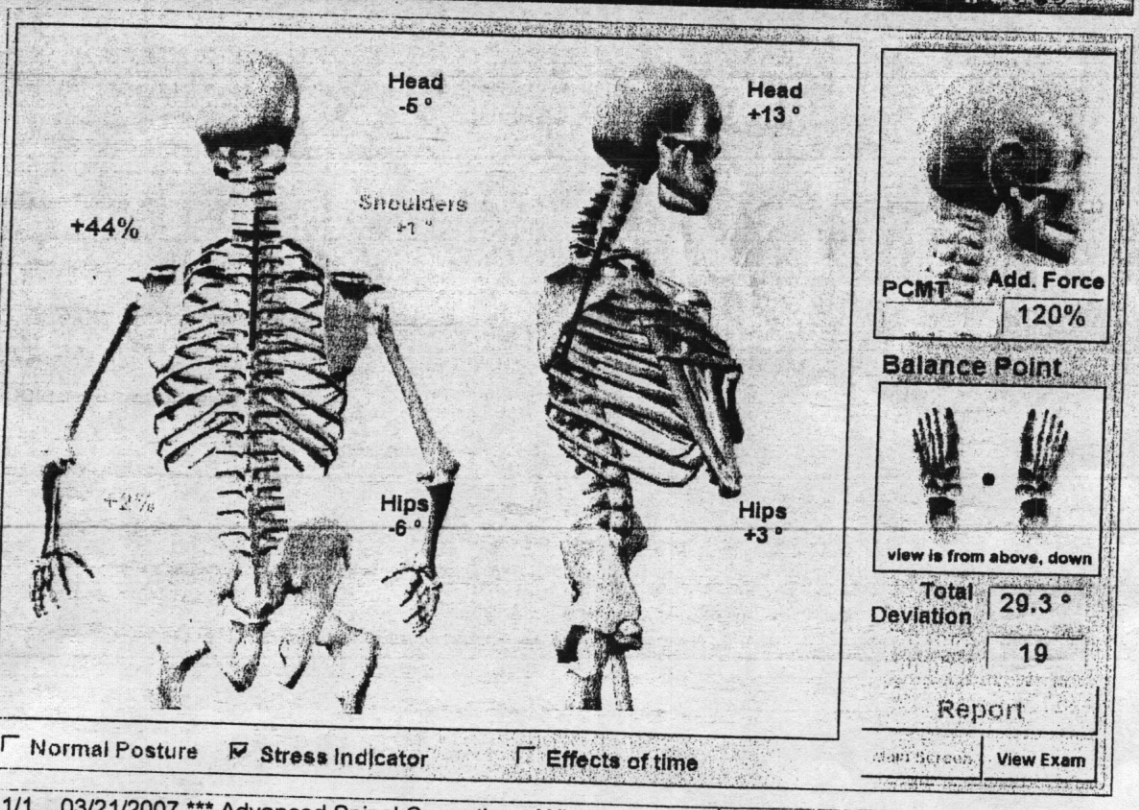
A posture exam was performed on Tiffany Anderson on 03/21/07 16:41 using the Posture Pro V posture analysis system. Anatomical landmarks were selected bilaterally on the head, torso, hips (ankles and knees if indicated) on the AP view, and head, shoulder and hip, on the lateral view. Lines were drawn through these landmarks to create angles. Normal posture profile would be zero degrees for all indicators. The results follow.

BWR: BWL: CT Comp. - Off;
Nonzero offsets: AP-Hd=-5 °; AP-S=1 °; AP-H=-6 °; AP-K=-2 °; LAT-Hd=13 °; LAT-P=3 °;
CF=120%; PDv=29.3 °; Q-Angles N/A



A posture exam was performed on Tiffany Anderson on 03/21/07 16:41 using the Posture Pro V posture analysis system. Anatomical landmarks were selected bilaterally on the head, torso, hips (ankles and knees if indicated) on the AP view, and head, shoulder and hip, on the lateral view. Lines were drawn through these landmarks to create angles. Normal posture profile would be zero degrees for all indicators. The results follow.

BWR: BWL: CT Comp. - Off;
Nonzero offsets: AP-Hd=-5 °; AP-S=1 °; AP-H=-6 °; AP-K=-2 °; LAT-Hd=13 °; LAT-P=3 °;
CF=120%; PDv=29.3 °; Q-Angles N/A



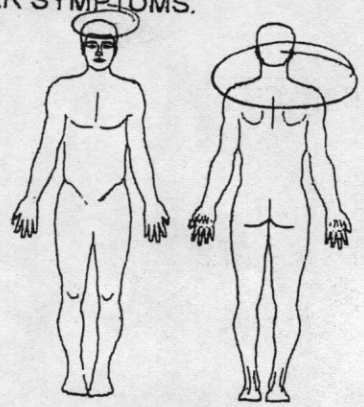
GERARD 08-20-4

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

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name Tiffany Anderson Birthdate 8-22-70 Sex M / F
Address 1414 Iris Drive #7 City Lodi
State CA Zip 95242 Telephone (209) 333-1037 CELL Phone 209-329-2339
Occupation pesticide applicator Employer SJCMVCD Work Phone 982-4675
Address 7759 Airport Way City Stockton State CA 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 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: 06

How Problem Began: Stress

Current complaint (how you feel today):

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

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?

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

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☒ Yes
Date(s) taken: **What areas were taken?** Shoulders

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (date)
☐ Corticosteroid Use (cortisone, prednisone, etc.)
☒ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain)
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain)

☐ Prostate Problems
☒ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☒ Pain at Night
☐ Visual Disturbances
☐ Surgeries
☐ 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 doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature Date 8-20-08

GERARD 08-10-6

American Specialty Health Plans of California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 50-9002
Fax: 877/427-4777

SUPPORTIVE CARE
(Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson, Tiffany (Last, First, Initial) Sex: M / F Birthdate 7-27-70 (mm/dd/yyyy) Patient ID# 000789764

Subscriber Name: _____ Subscriber ID#: _____ Is This? ☐ Work Related ☐ Auto Related

Health Plan: Kaiser Primary ☐ Secondary ☐ Employer: _____ Group #: 000000030305

Treating D.C.: DR. JAMES GERARD
Address: 10 W. LOCUST ST.
City/State/Zip: LODI, CA. 95240
Phone: (209) 333-2401 Fax: (209) 339-4589

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: 1416 IRIS DR #7
City/State/Zip: Lodi, Ca. 95242
Phone: (209) 333-1032

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):
1. 729.2 Cervical Radiculitis
2. 739.1
3. 739.2
4. _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: 6/4/08 Through: 6/30/08 (UP TO 120 DAYS) | 3 # Office Visits | 3 # Therapies

☒ Established Exam (performed within above dates)
Date of Exam Findings: (mm/dd/yyyy) 6/4/08
Adj./Manip.: (Type) DIV
Therapy: (Type) MS
Supports/Appliances: _____
X-ray Views (performed within above dates): _____

(ALL SERVICES FOR SUPPORTIVE CARE SHOULD BE RENDERED ON PRN STATUS)

DATE OF MOST RECENT VISIT (mm/dd/yyyy): 6/4/08

BASIS FOR PERMANENCY:

Chief Complaints: NP/MBP w/ ® radiating to ® shoulder

Current Exam Findings: ↓ c/s ROM lat flex/ + ext. trigger point tenderness ® trap + levator scapulae @ ↓ P-A jt motion in T/sp T2-5

Imaging Studies Obtained (views taken): _____ Date taken: _____

Findings: _____

HAVE THERE BEEN ATTEMPTS TO WITHDRAW CARE? ☒ No ☐ Yes, please explain: _____

HAVE LIFESTYLE MODIFICATIONS BEEN CONSIDERED AND ATTEMPTED? ☐ No ☒ Yes, please explain: modify aggravating activity

HAS HOME-BASED SELF-CARE BEEN CONSIDERED AND ATTEMPTED? ☐ No ☒ Yes, please explain: ice

HAVE EXERCISE (ACTIVE REHABILITATION) INSTRUCTIONS BEEN PROVIDED? ☐ No ☒ Yes, explain: c/sp stretches

HAS MANAGEMENT OR CO-MANAGEMENT BY PCP, PSYCHOLOGIST OR OTHER SPECIALIST(S) BEEN CONSIDERED AND ATTEMPTED? ☒ No ☐ Yes, explain: _____

OBJECTIVES OF CARE: Decrease overall ®, improve ROM + ↓ @ spasm in c/sp + T/sp.

Signature of treating D.C. (Required): _____ Date: 6/10/08

GERARD 08-20-5

American Specialty Health Plan · California, Inc. (ASH Plans)
P.O. Box 509002, San Diego, CA 150-9002
Fax: 877/427-4777

RECONSIDERATION / MODIFICATION
(Chiropractic)

For questions, please call ASH Plans at 800/972-4226

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

Patient Name Anderson (Last) Tiffany (First) _____ (Initial) Patient ID # 0007897964-01

Patient Health Plan: Kaiser

Treating D.C.: DR. JAMES GERARD

Address: 10 W. LOCUST ST.

City/State/Zip: LODI, CA. 95240

Phone: (209) 333-2401 Fax: (209) 339-4589

List the appropriate Treatment Form Number for this request.

ASH PLANS TREATMENT FORM #

8403406

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 and additional information may also be attached or included below.

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

☐ **X-Rays and/or Radiological Consultation**

Views required: _____

Rationale for films/consult: _____

☐ **Supports / Appliances**

Supports/Appliances required: _____

☒ **Dates of Service – Changes, Extensions** (up to 30 days), **Reductions**

The treatment period/dates should be: Start (mm/dd/yyyy) 3/22/08 End (mm/dd/yyyy) 5/20/08

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 and/or therapies may not be submitted with a date extension.

Pt has had gradual increase in the left trap and neck symptoms. No specific injury.

☐ **Additional Therapies**

Number of submitted therapies: #_____ Please list the types of therapies (e.g., ultrasound) and rationale:

☐ **Other**

Services/Clinical Rationale: _____

Signature of treating D.C. (Required): _____ Date: 5-20-08

Gerard 08-25-3

American Specialty Health Plans California, Inc. (ASH Plans)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877/427-4777

CLINICAL TREATMENT FORM
(Chiropractic)
For questions, please call ASH Plans at 800/972-4226

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

Patient Name: Anderson (Last) Tiffany (First) (Initial) Sex: M / F Birthdate: 08/22/70 (mm/dd/yyyy) Patient ID# DCL7297064-01

Subscriber Name: _____ Subscriber ID#: _____ ☐ Work Related Is This? ☐ Auto Related

Health Plan: Kaiser Primary ☐ Secondary ☐ Employer: _____ Group #: 00007203045

Treating D.C.: DR. JAMES GERARD
Address: 10 W. LOCUST ST.
City/State/Zip: LODI, CA 95240
Phone: 209)333-2401 Fax: (209) 339-4589

PATIENT MAILING ADDRESS AND PHONE NUMBER
Address: 1416 Iris Drive #7
City/State/Zip: Lodi, Ca. 95240
Phone: (209) 333-1032

DATES OF SERVICES RENDERED UNDER THE TREATMENT FORM WAIVER: (Required) ☐ No services rendered.

Exam/1st OV date (mm/dd/yyyy) current benefit year: _____ Response to care: _____
Last OV date under TFW: 12/8/07
Total # of OVs rendered under TFW: 5
X-rays/Supports (CPT Codes): _____

ICD-9 CODES / DIAGNOSES (must be to the highest level of specificity):
1. 723.4 Cervical Radiculitis 3. _____
2. _____ 4. _____

TREATMENT/SERVICES SUBMITTING FOR REVIEW:

From: 2/22/08 Through: 4-22-08
Estimated Date of Release: (Required) 4-22-08
Exam (performed within above dates): ☐ New ☒ Established
Date of Exam Findings: (mm/dd/yyyy) 2/22/08
Adj./Manip.: (Type) MGV
Therapy: (Type) _____
Supports/Appliances: _____
X-ray Views (performed within above dates): _____

	# Office Visits	# Therapies
0 - 15 days	3	
16 - 30 days		
31 - 45 days		
46 - 60 days		
TOTAL	3	

IMAGING STUDIES: Date taken: _____ Views _____ ☐ Taken at outside facility
Findings: _____
Rationale for films: _____

CHIEF COMPLAINTS: 1 neck ant 2 Lt trap 3 pain (T4) 4 Eval
DATE OF ONSET: (mm/dd/yyyy) 2-17-08
MECH. OF INJURY/EXACERBATION: Overexertion
PERTINENT PAST HISTORY: Chronic neck

VITAL SIGNS: Height 5'-3½ Weight 138 Blood Pressure 91/66 Temp _____
ROM: Cervical spine: ☐ N/A ☐ All WNL Flexion 50/60 or ___% limited Extension 22/50 or ___% limited
Lat flex Left 32/40 or ___% limited Right 32/40 or ___% limited Rotation Left 75/80 or ___% limited Right 65/80 or ___% limited
Lumbosacral spine: ☐ N/A ☐ All WNL Flexion ___/90 or ___% limited Extension ___/30 or ___% limited
Lat flex Left ___/20 or ___% limited Right ___/20 or ___% limited Rotation Left ___/30 or ___% limited Right ___/30 or ___% limited
Other: _____

ORTHO/NEURO/VASCULAR/VBI: ☐ N/A ☐ All WNL (Please include location and intensity of findings.) foramen comp (T4) to Lt scapula

CHIROPRACTIC/PALPATORY ASSESSMENT: C-T spasm Lt

FUNCTIONAL ASSESSMENT/IMPROVEMENT: _____

EXERCISE/HOME CARE: Pt is carrying out w/ sites
OUTCOME ASSESSMENTS: ☐ N/A Date score obtained: _____ ☐ Neck Disability score ___ ☐ Roland-Morris score ___
☐ Oswestry Low Back score ___ ☐ Perceived Improvement ___ % ☐ Other (name) score ___
ADD'L. COMMENTS: _____

Signature of treating D.C. (Required): _____ Date: 3-25-08