American Specialty Health Plans of California, 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: 000000030305

Treating D.C.: DR. Gerard
Address: 575 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), Foraminal comp (+4) to both hands, FLB 42, EXT 22, LLF 32, RLF 25, LR 65, RR 60

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

☐ **Other**
Services/Clinical Rationale: Pt has a follow-up in late April

Signature of treating D.C. (Required): [signature] Date: 5-4-07