GERARD 08-20-5

American Specialty Health Plan 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 # 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) 2/22/08 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 a 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