

FOR ASH PLANS ONLY	ASH PLANS TREATMENT FORM #	RECEIVED DATE	ASH PLANS CLINICAL SERVICES MANAGER
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Patient Name Anderson, Tiffany Patient ID # 007897964-01  
Last First Initial 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) vestibular ROM, de-tend's palp C-T, Foam comp to both (+4) shoulders and shoulder depts. 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 Mrs Anderson's last report (7-24-07) she had used 2 of her visits. She had all the up around 8-1-07 and has been in for weekly tx.

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