

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 800/872-4226

FOR ASH PLANS  
USE ONLY

ASH PLANS TREATMENT FORM #

RECEIVED DATE

ASH PLANS CLINICAL SERVICES MANAGER

Patient Name

Anderson Tiffany

Patient ID # 007897964.07

Patient Health Plan Kaiser

Treating D.C.

Dr. James Gerard

Address

515 S Fairmont Ave. B

City/State/Zip

Los Angeles CA 95240

Phone

(209) 333-2401 Fax (209) 333-9208

List the appropriate Treatment Form Number for this request.

**ASH PLANS TREATMENT FORM #**

7941332

**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) 10/19/06 End (mm/dd/yyyy) 12/14/06

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

☐ **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):

*[Signature]*

Date: 12-20-06

r77 P dc thw RcnsgnMod 11-2 05 doc

02/01/2008