ACN Group Notification Form

Patient #: _____

Instructions
Complete this form and mail or fax it to ACN Group within 3 days of the initial date of service.

◯ Female
◯ Male

Patient's Name: (Last, First, M) ***Patient's Date of Birth:***

Patient's Address ***City*** ***State*** ***Zip***

Patient's Insurance ID# ***Health Plan*** ***Group Number***

Referral Info If Required ◯ *Yes* ◯ *No*

Referred *Referring Provider* *Date Referral Issued* *Referral #* *Condition Referred For*

This Notification Form Initial Date of Service

Nature of Condition
1. *Initial onset (within last 3 months)*
2. *Recurrent (multiple episodes of <3 months)*
3. *Chronic (continuous duration >3 months)*

Current Functional Status
Neck Index ***SF-12 PCS***
Back Index ***SF-12***

Treatment Duration (months)
◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ 5 ◯ 6 ◯ 12

Cause of Current Episode
1. *Traumatic*
2. *Unspecified*
3. *Repetitive*
4. *Post-surgical*
5. *Work related*
6. *Motor vehicle*

Diagnosis
Primary ___.___ ___.___

Patient Type
1. *New to Your Office*
2. *Est'd, new to ACN Group*
3. *Est'd new injury*
4. *Est'd, new episode*
5. *Est'd, continuing care*

Anticipated Status After This Episode
1. *MTB, no residuals, no discharge*
2. *MTB, residuals, discharged*
3. *MTB, residuals, PRN/supportive care*
4. *Not at MTB, update tx goals/plan*
5. *Referred/transferred*

Anticipated Code Level
CMT ◯ *98940* ◯ *98941* ◯ *98942* ◯ *98943*
E/M - New ◯ *99201-03* ◯ *99204* ◯ *99205*
E/M - Est'd ◯ *99211-13* ◯ *99214* ◯ *99215*

Check Those That Apply - *add comments to the right*

◯ *Treatment plan includes >1 procedural/modality per visit (not including exercise instruction). Describe/give rationale.)* _____
◯ *Xray exposure is anticipated/has occurred. Describe/give rationale.* _____
◯ *Lab, EMG (needle or surface) were performed. Describe/give rationale.* _____
◯ *Treatment plan does not include active care instruction and homecare advice during the first week. Explain.* _____
◯ *There are significant co-morbidities that prevent delivery of a typical treatment plan. Describe.* _____
◯ *There are significant co-morbidities/complicating factors that are delaying recovery. Describe.* _____
◯ *I would like to discuss this treatment plan with a support clinician. Describe/explain.* _____

Provider Name ***Provider ID***

Office Address ***City*** ***State*** ***Zip***

I declare that the information on this form is true and accurate to the best of my knowledge. It is my professional judgment that the treatment plan is not contraindicated for this patient.

Provider Signature ***Date***

ACN Use Only
rev 11/22/2002

Effective Date ***Reference Number*** ***Overlap***