ACN group.

Voluntary Prior Approval Process

1. You sign this Voluntary Prior Approval Agreement Form upon your initial visit to indicate that you are opting to obtain prior approval for non-participating chiropractic services, that you understand the process, that you agree to the procedures described here and that you authorize your non-participating chiropractor to submit information on your behalf.

2. You ask your non-participating chiropractor to submit a completed one page Patient Summary form, a one page Patient Health Questionnaire (PHQ), along with this signed Voluntary Prior Approval Agreement form directly to ACN Group (fax to 845-382-6294). You or your non-participating chiropractor can obtain a copy of the Patient Summary & PHQ forms by calling ACN Group at 1-800-985-3293 or by visiting ACN Group's web site at *www.acnprovider.com.*

3. ACN Group will respond to both you and your chiropractor for each Patient Summary form received, indicating the time frame and services that have been approved or that the services have not been approved.
   a. If the services are approved, you are responsible only for out-of-network cost shares (e.g., deductible and coinsurance).
   b. If the services are not approved and you choose to receive care, you will be responsible for the cost in full. You may appeal that decision by following the procedures attached with the response or as described in your Certificate of Coverage.

4. If your chiropractor believes that you need care beyond the approved number of services and/or time frame provided, he/she should submit a new updated Patient Summary Form, including asking you to complete a new Patient Health Questionnaire to assess your progress. *If the new forms are not submitted, the claims will be reviewed retrospectively as described.*

5. If you change non-participating chiropractors and wish to continue to use the Voluntary Prior Approval process, the new chiropractor should submit your new **Voluntary Prior Approval Agreement Form** along with a newly completed Patient Summary Form and Patient Health Questionnaire.

Submission of this form indicates that you understand the Voluntary Prior Approval process; you agree to the procedures outlined in this letter and that you authorize your non-participating chiropractor to submit a Patient Summary Form/PHQ on your behalf.

Chiropractor's Name: _____

Clinic Name (if available) _____

Chiropractor's Street Address: _____

Chiropractor's City, State & Zip: _____

Chiropractor's Tax Identification Number: _____

Chiropractor's Phone Number: _____

Member's Name: _____ Member's DOB: _____

Member's Oxford ID Number: _____

Member/Guardian Signature: _____ Date: _____

Patient Summary Form
PSF-750 (Rev. 7/1/2015)

Patient Information

Patient name	Last	First	MI	○ Female ○ Male

Patient date of birth

Patient address   City   State   Zip code

Patient insurance ID#   Health plan   Group number

Referring physician (if applicable)   Date referral issued (if applicable)   Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)   2. Federal tax ID(TIN) of entity in box #1

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1   5. NPI of entity in box #1   6. Phone number

7. Address of the billing provider or facility indicated in box #1   8. City   9. State   10. Zip code

---

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type
- (1) New to your office
- (2) Est'd, new injury
- (3) Est'd, new episode
- (4) Est'd, continuing care

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

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

Date of Surgery

Type of Surgery
- (1) ACL Reconstruction
- (2) Rotator Cuff/Labral Repair
- (3) Tendon Repair
- (4) Spinal Fusion
- (5) Joint Replacement
- (6) Other ____

DC ONLY
Anticipated CMT Level
- ○ 98940
- ○ 98941
- ○ 98942
- ○ 98943

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Current Functional Measure Score

Neck Index		DASH	
Back Index		LEFS	(other FOM)

Patient Completes This Section:
(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10) worst pain

Past week: no pain (0)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10) worst pain

4. How often do you experience your symptoms?
- (1) Constantly (76%-100% of the time)
- (2) Frequently (51%-75% of the time)
- (3) Occasionally (26% - 50% of the time)
- (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
- (1) Not at all
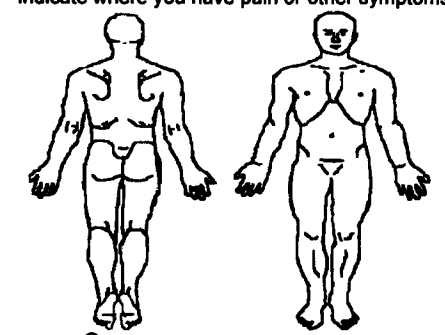- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

6. How is your condition changing, since care began at *this* facility?
- (0) N/A — This is the initial visit
- (1) Much worse
- (2) Worse
- (3) A little worse
- (4) No change
- (5) A little better
- (6) Better
- (7) Much better

7. In general, would you say your overall health right now is...
- (1) Excellent
- (2) Very good
- (3) Good
- (4) Fair
- (5) Poor

Patient Signature: X _____   **Date:** _____

Back Index

ACN Group, Inc.   Form BI-100

Patient Name _____   **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life.
Please answer every section by marking the one statement that applies to you. If two or more statements in one
section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Back Index Score ☐

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100