



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)

Instructions
 Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.
 Please review the Plan Summary for more information.

Patient Information

Female
 Male

Patient name: Last [] First [] MI [] 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: []

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: [] [] []

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

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)

DC ONLY Anticipated CMT Level
 ① 98940 ② 98942 ③ 98941 ④ 98943

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

Diagnosis (ICD codes)
 Please ensure all digits are entered accurately.
 1° [] [] [] [] [] []
 2° [] [] [] [] [] []
 3° [] [] [] [] [] []
 4° [] [] [] [] [] []

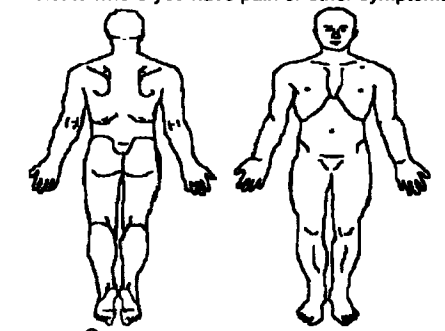
Current Functional Measure Score
 Neck Index: [] DASH [] [] [] []
 Back Index: [] LEFS [] [] [] [] (other FOM)

Patient Completes This Section:

Symptoms began on: [] [] []

1. Briefly describe your symptoms: _____
 2. How did your symptoms start? _____
 3. Average pain intensity:
 Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain
 Past week: no pain 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?
 ① N/A — This is the initial visit ② Much worse ③ Worse ④ A little worse ⑤ No change ⑥ A little better ⑦ Better ⑧ 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

Indicate where you have pain or other symptoms:



Patient Signature: X _____ Date: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your neck 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

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓐ 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, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

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

Neck
Index
Score