ACN Group Notification Form

ACN Group, Inc. - Form - NF-202

◯ Female
◯ Male

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

Patient's Name (Last, First, MI) | Patient's Date of Birth

Patients Address | City | State | Zip | ◯ Prim ◯ Sec

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

Referral Info If Req'd ◯ 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 MCS

Treatment Duration (months)

◯ 1 ◯ 2 ◯ 3 ◯ 4
◯ 5 ◯ 6 ◯ 12

Cause of Current Episode

① Traumatic ④ Post-surgical
② Unspecified ⑤ Work related
③ Repetitive 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, discharged
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 procedure/modality per visit (not including exercise instruction). Describe/give rationale

◯ Xrays are anticipated/have been taken for this episode.. 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 judgement that the treatment plan is not contraindicated for this patient.

Provider Signature | Date

ACN Group Use Only
rev 12/13/2002

Effective Date | Reference Number | Overlap