American Specialty Health
Acupuncture
Required Forms

January 2011 ■ California Version 11.0

1. Clinical Treatment Form
2. Initial Health Status
3. Patient Progress
4. Reopen / Modification
5. Informed Consent and Disclosure
6. Member Billing Acknowledgment
7. Provider Status Change Request
CLINICAL TREATMENT FORM – Acupuncture

Patient Name ____________________________ Sex M / F Birthdate mm/dd/yyyy Patient ID # ____________

Subscriber Name ____________________________ Subscriber ID # ____________________________ Employer ____________________________

Health Plan ____________________________ Secondary Group # ____________________________ Is this? □ Work Related? □ Auto Related?

PCP Name ____________________________ Phone # ____________________________

Clinic Name ____________________________

Treat Provider ____________________________

Address ____________________________

City/State/Zip ____________________________

Phone ( ) Fax ( )

CONDITION TREATED, DIAGNOSIS AND ICD-9 CODE

1. ____________________________ ____________________________  □ Acute Condition □ Chronic Condition □ Continuing Care
2. ____________________________ ____________________________  □ Co-managed Care □ Supportive Care
3. ____________________________ ____________________________  Eastern Diagnoses:
4. ____________________________ ____________________________

TREATMENT/SERVICES SUBMITTING FOR REVIEW

Date: From ___/___/____ Through ___/___/____ □ Acupuncture □ Electro-stimulation □ Acupressure/Tui-Na □ Home Care Advice

Total # Office Visits/Acupuncture ____________________________ □ Diet □ Cupping □ Cold/Heat Pad □ GuaSha □ Herbs □ Infrared/Heat Lamp

□ Established Patient Exam Date ____________________________ □ Moxibustion □ Rehab Exercise □ Nutritional Supplements ____________________________

Estimated Date of Release _____/_____/______ □ Other ____________________________

Treatment Goal:

Services provided prior to today and the treatment outcome:

Total # of Treatments _____ performed. Patient’s response to care ____________________________

Pain has □ Decreased □ No Change □ Worsened □ Decreased only for a short period of time ____________________________

Functional Ability Change □ Improving □ No Change □ Getting Worse. Explain: ____________________________

Current main complaint(s) ____________________________

Mechanism of injury/date of onset □ Traumatic □ Repetitive □ Exacerbation □ Recurrent / Chronic □ Unknown □ Post-Surgical ______

Pertinent health history ____________________________

Other ongoing treatments (e.g., medications, therapies) ____________________________

____________________

Height ________, Weight ________ lb, BP ________/______/______ mmHg, Temperature ________, Pulse ________

Summary of your examination findings (or attach page 2): Date of exam _____/_____/______ Findings: ____________________________

Activities of Daily Living are □ normal □ mildly affected □ severely affected: ____________________________

Observation ____________________________

Palpation ____________________________

Range of Motion ____________________________

Orthopedic Testing ____________________________

Neurological Assessment ____________________________

Tongue Signs ____________________________. Pulse Signs R: ____________________________ L: ____________________________

Additional Clinical Findings ____________________________

PLEASE SUBMIT THIS FORM WITH INITIAL HEALTH STATUS (INITIAL CARE) OR PATIENT PROGRESS FORM (ONGOING CARE)

Signature of treating acupuncture provider ____________ Date ____________
Acupuncture Clinical Findings

Pain Descriptions:

<table>
<thead>
<tr>
<th>Pain Condition #1:</th>
<th>Location</th>
<th>Intensity (1-10)</th>
<th>Frequency</th>
<th>Duration (hours/days)</th>
</tr>
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<tbody>
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</tbody>
</table>

- Pain is [ ] Sharp  [ ] Dull  [ ] Stabbing  [ ] Burning  [ ] Spasmodic  [ ] Tingling  [ ] Throbbing  [ ] Stiffness  [ ] Distension or ___________
- Aggravating factors: ___________
- Alleviating factors: ___________

<table>
<thead>
<tr>
<th>Pain Condition #2:</th>
<th>Location</th>
<th>Intensity (1-10)</th>
<th>Frequency</th>
<th>Duration (hours/days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

- Pain is [ ] Sharp  [ ] Dull  [ ] Stabbing  [ ] Burning  [ ] Spasmodic  [ ] Tingling  [ ] Throbbing  [ ] Stiffness  [ ] Distension or ___________
- Aggravating factors: ___________
- Alleviating factors: ___________

Other Pain Conditions: ___________

Clinical Findings Related to Pain Location:

Head:
- Pain with [ ] Nausea/Vomiting  [ ] Fever/Chills  [ ] Dizziness  [ ] Phono/Photophobia  [ ] Neck Rigidity
- Neurologic Deficit  [ ] Sensation  [ ] Strength  [ ] Speech  [ ] Vision  [ ] Hearing  [ ] Cognition  [ ] Memory  [ ] Eye Motion/Pupils React

Neck:
- Muscle Spasm  [ ] Mild  [ ] Moderate  [ ] Severe
- Postural Abnormalities  [ ] Radiating Pain To ___________
- Functional Limits

Back:
- Muscle Spasm  [ ] Mild  [ ] Moderate  [ ] Severe
- Postural Abnormalities  [ ] Scoliosis  [ ] Radiating Pain To ___________
- Functional Limits

Extremities, Hip(s) and Shoulder(s):
- Muscle Spasm  [ ] Mild  [ ] Moderate  [ ] Severe
- Color change  [ ] Deformity  [ ] Radiating pain to ___________
- Functional Limits

- Neurologic Deficit Location ___________  [ ] Weakness  [ ] Abnormal Sensation  [ ] Reflexes (Increased/Decreased)

ROM of Affected joint(s) Use measurement or indicate if ROM Within Normal Limits (WNL), mildly, moderately or severely limited:

<table>
<thead>
<tr>
<th>Joints</th>
<th>Flexion / Extension</th>
<th>Lateral Flexion R / L</th>
<th>Rotation R / L</th>
<th>Rotation Int./Ext.</th>
<th>Abduction / Adduction</th>
<th>Other</th>
</tr>
</thead>
</table>

Orthopedic/Neurological Test Findings: E.g., Axial Compression ______ ; Patrick’s (Fabere) _______ ; Straight Leg Raising_________

Abdominal Pain:
- Associate Symptoms: [ ] Fever  [ ] Nausea/Vomit  [ ] Gas/Distension  [ ] Heartburn/Reflux  [ ] Constipation  [ ] Diarrhea or ______
- Palpable Mass at ___________  Tenderness at ___________  Rebound Tenderness ___________
- Bowel Movement Sounds (Increase/Decrease) ___________
- Other Findings ___________

Menstrual Pain: Menstrual Cycle ___________ days. Other Symptoms ___________

Additional Clinical Findings (including Lab / Radiographic Exams)

Outcome Assessments (List both Initial and Current date(s) with score(s) for applicable tests)

<table>
<thead>
<tr>
<th>List Date Obtained</th>
<th>Initial</th>
<th>Current</th>
<th>Initial</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
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<td>___ / __________ / ___</td>
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</tr>
<tr>
<td>Roland-Morris score</td>
<td>Neck Disability Index score</td>
<td>Oswestry score</td>
<td>LEFS (Lower Extrem.) score</td>
<td></td>
</tr>
<tr>
<td>Oswestry score</td>
<td>LEFS (Lower Extrem.) score</td>
<td>Pain scale (0-10) score</td>
<td>DASH (Upper Extrem.) score</td>
<td></td>
</tr>
<tr>
<td>Pain scale (0-10) score</td>
<td>DASH (Upper Extrem.) score</td>
<td>Other</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Signature of treating acupuncture provider ___________

Examination Date (required) ___________
American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA  92150-9001
Fax: 877.248.2746

INITIAL HEALTH STATUS
Acupuncture
For questions, please call ASH at 800.972.4226

Patient Name ___________________________ Birthdate ___________ Primary Language ________ Sex M / F

Address _________________________________ City ________________ State ______ Zip ______ Primary Phone ______

Employer _________________________________ Occupation __________________ Other Phone ________

Subscriber Name _________________________ Subscriber ID # ____________ Group # ________________

Primary Health Plan ___________________________ Patient/Member ID # ________

2nd Health Plan ___________________________ Primary Care Physician (PCP) ___ (Required) PCP Phone # _____ (Required)

Are you under the care of a physician? □ No □ Yes, for what conditions?

Please describe your current health problem(s)

How and When it began ___________________________ Is this work related? Y / N

What treatment have you received for the above condition(s)? □ Surgery □ Medications □ Physical Therapy
□ Injections □ Chiropractic □ Massage □ Other

Please describe your progress: □ Worse □ No Change □ 25% Better □ 50% Better □ 75% Better or ____________

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back,
Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? □ Constantly □ Frequently □ Intermittently □ Occasionally

Describe your current health condition: □ Excellent □ Very Good □ Good □ Fair □ Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

□ Alcohol/Drug Dependence □ Frequent Urination □ Stroke
□ Abnormal Menstruation □ Headache □ Tobacco Use - Type___________
□ Allergies □ Heart Attack □ Frequency_________/Day
□ Angina □ Heartburn or Indigestion □ Thyroid Disease
□ Arthritis/ □ High Blood Pressure □ Other___________
Rheumatoid Arthritis □ Hospitalizations/Surgical
□ Artificial Joints □ Procedures__________________________
□ Asthma
□ Blood Disorder □ Kidney Disease
□ Breast Lumps □ Liver Problems
□ Cancer/Tumor □ Osteoporosis
□ Convulsions/Seizures □ Pacemaker
□ Diabetes □ Palpitation/Arrhythmia
□ Diarrhea/Constipation □ Peptic Ulcer
□ Excessive Thirst □ Pregnant, # Weeks___________
□ Fainting or Dizziness □ Prostate Problems
□ Fatigue □ Weight Gain/Loss
□ Fever □ Sinusitis

If a family member has had any of the following, please mark the appropriate box and explain the relationship:

□ Cancer
□ Heart Disease
□ Hypertension
□ Lupus
□ Other

Comments

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan
information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I
understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I
have changes in my health condition or health plan coverage. I understand that my provider of acupuncture
services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-
managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor
if necessary.

Patient signature ___________________________ Date ___________
Patient Name

Patient, please complete the following questions regarding how you feel today and in the past week.

1. How do you feel today?

Circle your pain level today.
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

In the past week, how often have your symptoms been present?

☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally ☐ None

Circle your average and the worst pain level over the past week.
No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Currently, how much has your pain interfered with your daily activities?
No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

2. Are you getting better?

<table>
<thead>
<tr>
<th>Current Condition(s)/Complaint(s)</th>
<th>Rate your overall progress since starting acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td>1_______________________________</td>
<td>☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse</td>
</tr>
<tr>
<td>2_______________________________</td>
<td>☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse</td>
</tr>
<tr>
<td>3_______________________________</td>
<td>☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse</td>
</tr>
<tr>
<td>4_______________________________</td>
<td>☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Worse</td>
</tr>
</tbody>
</table>

3. Which type(s) of treatment have been helpful to your condition(s)?

☐ Acupuncture treatment ☐ Nutritional supplements ☐ Rehab Exercise/Home Care
☐ Chinese herbs ☐ Prescription Medication(s) ☐ Spinal Adjustment/Manipulation
☐ Massage therapy ☐ Physical therapy ☐ Other________________________

4. Is there anything new?

Have you had any new complaints/conditions? ☐ No ☐ Yes Explain________________________

Have you had any re-injuries or events that have prolonged your recovery? ☐ No ☐ Yes
Explain________________________

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature________________________________________ Date__________
## REOPEN / MODIFICATION

**Acupuncture**

For questions, please call ASH at 800.972.4226

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### FOR ASH USE ONLY

<table>
<thead>
<tr>
<th>ASH TREATMENT FORM #</th>
<th>RECEIVED DATE</th>
<th>ASH CLINICAL SERVICES MANAGER</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Patient Information

- **Patient Name**: [Last Name] [First Name] [Initial]
- **Patient ID#**: [Enter Patient ID]
- **Patient Health Plan**: [Enter Health Plan]
- **Acupuncture Provider**: [Enter Provider Name]
- **Address**: [Enter Address]
- **City/State/Zip**: [Enter City, State, Zip]
- **Phone**: (____)______
- **Fax**: (____)______

### Treatment Form Number

List the appropriate Treatment Form Number for this submission.

**ASH TREATMENT FORM #**

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### Reopen Option

- **REOPEN (Peer to Peer Communication)**: This option should be chosen when submitting additional/revised information for clinical review to support treatment/services **not approved** in the original submission or to correct errors in the previously submitted information.

Please clarify which treatment/services you are submitting for Reopen and provide rationale. You may attach the current Clinical Treatment Form and additional information may also be attached or included below.

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### Reopen Requirements

Reopen submissions for pre-service adverse determinations require prior patient consent in the following states: Ohio

- In accordance with state regulatory requirements, I hereby attest to having the member’s consent prior to submitting this reopen. [Note: When submitting a reopen for patients in the states listed above, this box must be checked for the reopen to be processed.]

### Modification Option

- **MODIFICATION**: This option should **only** be chosen if you need to submit additional treatment/services beyond those previously submitted or change the approved dates of service.

- **Dates of Service – Changes, Extensions, (up to 30 days), Reductions**
  
  The treatment period/dates should be: Start (mm/dd/yyyy)_________________________ End (mm/dd/yyyy)____________________

  Rationale_________________________

- **Additional Office Visits** (up to 3 visits)

  Additional number of visits: #________ Please provide current subjective and objective findings and rationale. Please note that modification for additional office visits may **not** be submitted with a date extension.

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### Additional Examinations

- **Date of Examination**: __________________________

  Clinical Rationale____________________

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### Other Services/Clinical Rationale

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**Signature of treating acupuncture provider**: ____________________________  **Date**: __________

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01/01/2011
INFORMED CONSENT:

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Contracted Provider named above and/or other ASH Contracted Provider who may treat me. I understand that the ASH Contracted Provider will explain all known risks and complications, and I wish to rely on the ASH Contracted Provider to exercise judgment during the course of the procedure, which the ASH Contracted Provider determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Contracted Provider has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Contracted Provider’s use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH does not allow direct moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Contracted Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Contracted Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Contracted Provider. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

**Authorization for Release of Medical Information:** I further understand that my ASH Contracted Provider or an ASH acupuncture clinical services manager may need to contact my medical physician when the ASH Contracted Provider or an ASH acupuncture clinical services manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH to contact my medical physician if/when necessary.

**Treatment of Pediatric Patients <3 Years.** I understand that treatment of young children has some risk and should be coordinated with the child’s physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH to contact my child’s medical doctor if/when necessary.

Patient Name (please print)             Patient ID Number

Primary Care Physician (or specialist) Name

Primary Care Physician (or specialist) Telephone

Primary Care Physician (or specialist) Telephone

Date
IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, ________________, a member being treated by __________________, do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with __________________. (Name of Health Plan)

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
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</table>

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member’s payor. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Provider may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Provider may not bill the member for the difference between what the ASH Contracted Provider bills and what the ASH Contracted Provider agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Provider agreed contractually to waive.

This agreement may not be used as a “blanket” or “retroactive” agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement “void” and non-binding on the member. This agreement may only be used to allow the member to agree to “self pay” for specific services in advance.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, and agree to make financial arrangements with my provider, _____________________, to pay for these services myself.

Dated at _____________________, _____________, 20________. (city) (state) (date) (month) (year)

Member Signature
Member Health Plan ID#

Provider Signature
Date
PROVIDER STATUS CHANGE REQUEST

FOR QUESTIONS, CALL PROVIDER RELATIONS AT 800.972.4226, OPTION 4 • FAX COMPLETED FORM TO 866.545.2746

REQUIRED IDENTIFYING INFORMATION (Please use information currently in ASH system)

Provider Name ___________________________ Specialty ___________________________

NPI # □ Type 1 (Individual) ___________________________ NPI # □ Type 2 (Organization) ___________________________

TIN (SSN or EIN) for this location now listed in ASH system ___________________________

Clinic Name ___________________________

Clinic Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

Clinic Mailing Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

Clinic Billing Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

Clinic Telephone ( ) ___________________________

Web Address ___________________________

TYPE OF CHANGE (For TIN related changes, remember to include updated W-9 Form)

CHECK ALL THAT APPLY. ENTER DETAILS OF THESE CHANGES ON THE APPROPRIATE LINE IN THE DETAILS SECTION:

□ Moving Clinic Stated Above

□ Adding Clinic

□ Closing Clinic

□ Clinic/Business Name ___________________________

□ TIN Owner Name ___________________________

□ Taxpayer ID Number (SSN or EIN) Change ■ Attach updated W-9 Form for any TIN related change ■ Effective Date of New TIN ___________________________

Describe your relationship to the TIN owner reflected on the attached W-9 Form:

□ Individual/Sole Proprietor □ Employee □ Owner/Co-Owner ___________________________

□ New TIN ___________________________

DETAILS OF CHANGE(S) (State details of all changes checked above)

Separate forms are needed for each office location AND provider affected by the change(s).

Provider Name ___________________________ Specialty ___________________________

Clinic Name ___________________________

Clinic Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

□ Home □ Health Club/Gym □ Medical Building □ Office Building ___________________________

Clinic Mailing Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

Clinic Billing Address ___________________________ Ste ___________ City ___________________________ St ___________ Zip ___________

Clinic Telephone ( ) ___________________________

Clinic Fax ( ) ___________________________

Web Address ___________________________

Email Address ___________________________

Provider Signature (Required) ___________________________ Date ___________________________

The information stated herein serves to amend Attachment A of your in-force Provider Services Agreement ___________________________

Comments ___________________________

FAX COMPLETED FORM TO 866.545.2746 TOLL FREE