EviCore
By EVERNORTH

Musculoskeletal Program: Chiropractic, Physical Therapy, and Occupational Therapy Intake Form

Required for all MSK Conditions (Including Hand & Pelvic Pain)

Please use this fax form for NON-URGENT requests only. Failure to provide all relevant information may delay the determination. Phone and fax numbers may be found on eviCore.com under the Guidelines and Forms section. You may also log into the provider portal located on the site to submit an authorization request.

URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE

Previous Reference/Auth Number (If Continued Care):		**Date of Submission:**	
Service Type Requested:	☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Chiropractic**		
Place of Service:			

PATIENT

First Name:		MI:		Last Name:	
Member ID:		DOB (mm/dd/yyyy):		Gender: ☐ Male ☐ Female	
Street Address:				Apt #:	
City:		State:		Zip:	
Home Phone:		Cell Phone:		Primary: ☐ Home ☐ Cell	
Member Health Plan/Insurer:					

PA Health Plans ONLY : ORDERING PROVIDER

I agree that the Ordering Physician on this case is a registered MD, DO, PA, or NP ☐ Yes ☐ No

First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Physician Phone:		Physician Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

PROVIDER

First Name:		Last Name:			
Primary Specialty:		TIN:		NPI:	
Physician Phone:		Physician Fax:			
Address:				Suite #:	
City:		State:		Zip:	
Office Contact:		Ext:		Email:	

ADMINISTRATIVE

Diagnoses:

Code	*Description*	*Code*	*Description*

Start Date for this Request:

Is this request for fabricating a splint/orthotic or developing a home exercise program only? ☐ Yes ☐ No

If yes, stop here. If no, please continue.

Primary Treatment Area: Choose only one.

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Spine:	☐ Cervical / Upper Thoracic	☐ Lower Thoracic / Lumbosacral	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	☐ Hand
Lower Extremity:	☐ Hip / Thigh	☐ Knee	☐ Ankle / Foot / Leg
Other:	☐ Pelvic Pain / Incontinence		

Secondary Treatment Area: Choose only one. ☐ No second area being treated

Spine:	☐ Cervical / Upper Thoracic	☐ Lower Thoracic / Lumbosacral	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	☐ Hand
Lower Extremity:	☐ Hip / Thigh	☐ Knee	☐ Ankle / Foot / Leg
Other:	☐ Pelvic Pain / Incontinence		

Member Name:		Member ID:		Provider Name:	

Date of initial evaluation:		Date of current findings:		

Previous Treatment

Has the member been treated for any other condition in the past 6 months? ☐ N/A

Spine:	☐ Cervical / Upper Thoracic	☐ Lower Thoracic / Lumbosacral		
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	☐ Hand	
Lower Extremity:	☐ Hip / Thigh	☐ Knee	☐ Ankle / Foot / Leg	
Other:	☐ Pelvic Pain / Incontinence	☐ Neurologic/Developmental Condition	☐ Lymphedema	☐ Vestibular

Please ONLY complete the following section(s) based upon the Treatment Area(s) selected above.
Information specific to the Primary Treatment Area MUST be completed.

CERVICAL / UPPER THORACIC

TREATMENT AREA: Cervical / Upper Thoracic

Post-Surgical Care: ☐ Yes ☐ No *If yes, Date of Surgery:*

Surgery Type: ☐ Decompression ☐ Discectomy ☐ Fusion ☐ Total Disc Replacement ☐ Fracture/ORIF ☐ Post-mastectomy ☐ Other

Complete the following section for initial OR follow-up care as appropriate

	Initial	*Follow-Up*
Functional Assessment Used	☐Neck Disability Index score (NDI) (0-100%) ☐FOTO Neck (Focus on Therapeutic Outcomes) ☐Other/No Functional Assessment:	
Neck Disability Index score (NDI):	_____	Current _____ Initial score _____
Weakness, sensory changes or radiating pain below elbow:	☐ Yes ☐ No	☐ Yes ☐ No
Number of episodes in past 3 yrs:	☐ 1 ☐ 2 ☐ 3 ☐ ≥4 ☐ N/A	*N/A – Leave Blank for Follow-Up Request*
Has pt. responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No (Indicate the reason below)
	N/A – Leave Blank for Initial Request	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program ☐ Patient is post-surgery with signs of infection

UPPER EXTREMITY (ALL CONDITIONS)

TREATMENT AREA: Upper Extremity (All Conditions) **Side(s):** ☐ Left ☐ Right ☐ Bilateral

Post-Surgical Care: ☐ Yes ☐ No *If yes, Date of Surgery:*

If yes, Indicate Type of Surgery from Selection Below:

Shoulder/Arm	☐ Rotator Cuff	☐ Total Shoulder	☐ Biceps/SLAP Repair	☐ Instability	☐ Fracture/ORIF
	☐ Sub-Acromial Decompression	☐ MUA	☐ Post-mastectomy	☐ Other	
Elbow / Wrist / Forearm / Hand	☐ Tendon Repair/Debridement	☐ Ligament Repair	☐ Fracture/ORIF	☐ Carpal Tunnel Release	
	☐ Other Nerve Procedure	☐ Joint Replacement	☐ Debridement/Infection	☐ Osteochondral/Microfracture	
	☐ MUA	☐ Post-mastectomy	☐ Other		

Complete the following section below for initial OR follow-up care as appropriate

Functional Assessment Used: ☐ DASH (0-100) ☐ QuickDASH (0-100) ☐ FOTO Shoulder ☐ FOTO Elbow/Wrist/Hand ☐ Other/No Functional Assessment

	Initial	*Follow-Up*
Enter Score:	_____	Current score _____ Initial score _____
More than 3 blank answers?	☐ Yes ☐ No	*N/A – Leave Blank for Follow-Up Request*
Shoulder / Elbow: Does your patient demonstrate (*choose all that apply*)	☐ Loss of 15 degrees or more of elbow extension ☐ Recurrent subluxation/dislocation of shoulder ☐ Measurable (less than 4/5) weakness of shoulder joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension) ☐ Shoulder flexion OR abduction less than 120 degrees ☐ Fracture of humeral head, greater tubercle, OR olecranon process ☐ Patient has post-surgery swelling of Grade 2 or more (moderate) ☐ None of the above	

Member Name:		Member ID:		Provider Name:	

	HAND/WRIST ONLY: Does your patient demonstrate *(choose all that apply)*	☐ Crush injury OR fracture of distal radius or olecranon ☐ Total active range of motion of the thumb less than 100 degrees ☐ Total active range of motion of any other finger less than 130 degrees ☐ Post-surgical or post-traumatic swelling of grade 2 or more (moderate) ☐ None of the above	
	Patient responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No (Indicate the reason below)
		N/A – Leave Blank for Initial Request	☐ "Overdid" activities causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to participate in clinical visits/home program ☐ Patient is post-surgery with signs of infection

Please ONLY complete the following section(s) based upon the Treatment Area(s) selected.
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LOWER THORACIC / LUMBOSACRAL

TREATMENT AREA: Lower Thoracic / Lumbosacral

Post-Surgical Care:	☐ Yes ☐ No	*If yes, Date of Surgery:*		
Surgery Type:	☐ Decompression	☐ Discectomy	☐ Fusion	☐ Total Disc Replacement
	☐ Fracture/ORIF	☐ Scoliosis/Deformity	☐ Other	

Complete the following section for initial OR follow-up care as appropriate

Functional Assessment Used:	☐ Oswestry Disability Index (ODI) (0-100%) ☐ Roland Morris Questionnaire (RMQ) (0-24) ☐ FOTO Low Back (Focus on Therapeutic Outcomes) ☐ Other/No Functional Assessment	
	Initial	***Follow-Up***
Enter Score:	_____	Current score _____ Initial score _____
Number of episodes in past 3 yrs:	☐ 1 ☐ 2 ☐ 3 ☐ >4 ☐ N/A	*N/A – Leave Blank for Follow-Up Request*
Does your patient demonstrate either of the following:	☐ Weakness, sensory changes or radiating symptoms below the knee ☐ Tinetti Gait/Balance score < 24 OR Berg Balance test < 40 OR TUG test > 13.5 sec	
Has pt. responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No (Indicate the reason below)
	N/A – Leave Blank for Initial Request	☐ "Overdid" activities causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to participate in clinical visits/home program ☐ Patient is post-surgery with signs of infection

LOWER EXTREMITY (ALL CONDITIONS)

TREATMENT AREA: Lower Extremity (All Conditions) **Side(s):** ☐ Left ☐ Right ☐ Bilateral

Post-Surgical Care:	☐ Yes ☐ No	*If yes, Date of Surgery:*		
Indicate Type of Surgery from Selection Below:				
Knee:	☐ Total/Partial Replacement	☐ Ligament Reconstruction	☐ Arthroscopy (not ligament)	☐ Fracture/ORIF
	☐ Osteochondral/Microfracture	☐ Quadriceps/Patella Tendon Repair	☐ MUA	☐ Other
Hip:	☐ Total/Partial Replacement/Resurfacing	☐ Arthroscopy	☐ Fracture/ORIF	
	☐ Open Bursectomy/Capsulectomy	☐ Other		
Ankle/Foot/ Leg:	☐ Total Ankle Replacement	☐ Achilles/Other Tendon Repair	☐ Bunion Surgery	
	☐ Ligament Reconstruction	☐ Osteochondral/ Microfracture	☐ Fracture/ORIF	☐ Other

Complete the following section for initial or follow-up care as appropriate.

Functional Assessment Used: Choose only one.	☐ LEFS (0-80 score) ☐ HOOS Jr (0-100 interval score) ☐ KOOS Jr (0-100 interval score) ☐ FOTO Hip/Knee/Ankle/Foot (Focus on Therapeutic Outcomes) ☐ Other / No Functional Assessment	
	Initial	***Follow-Up***
Functional Score:	_____	Current score _____ Initial score _____
Does your patient demonstrate:	☐ Loss of 10 degrees or more of knee extension OR less than 5 degrees of ankle dorsiflexion	

Member Name:		Member ID:		Provider Name:	

		☐ Grade 3 or 4 laxity of the ankle or distal tibial-fibular joint ☐ Tinetti Gait/Balance score < 24 OR Berg Balance test < 40 OR TUG test > 13.5 sec ☐ Measurable (less than 4/5) weakness of hip joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension) ☐ None of the above	
	Has pt. responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No (Indicate the reason below)
		N/A – Leave Blank for Initial Request	☐ "Overdid" activities causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program ☐ Patient is post-surgery with signs of infection and/or persistent swelling of grade 2 or more (moderate)

Please ONLY complete the following section(s) based upon the Treatment Area(s) selected above.
Information specific to the Primary Treatment Area MUST be completed.

Pelvic Pain / Incontinence

TREATMENT AREA: Pelvic Pain / Incontinence		
Complete the following section for initial or follow-up care as appropriate.		
Indicate which patient reported outcome score was used from the selection below. If no score, select "None Used": ☐ None used		
	Initial	**Follow-Up**
☐ PFDI-20 (Pelvic Floor Distress Inventory	Summary score (0-300) _____	Current score _____ Initial score _____
☐ PFIQ-7 (Pelvic Floor Impact Questionnaire)	Summary score (0-300) _____	Current score _____ Initial score _____
☐ NIH-CPSO (NIH – Chronic Prostatitis Symptom Index)	Summary score (0-43) _____	Current score _____ Initial score _____
☐ ODI (Oswestry Disability Index)	_____ % (0-100)	Current score _____ % Initial score _____ %
☐ FOTO Urinary Problems (Focus on Therapeutic Outcomes)	_____	Current score _____ Initial score _____
☐ FOTO Pelvic Floor Dysfunction (Focus on Therapeutic Outcomes)	_____	Current score _____ Initial score _____
☐ FOTO Bowel Constipation (Focus on Therapeutic Outcomes)	_____	Current score _____ Initial score _____
☐ FOTO Bowel Leakage (Focus on Therapeutic Outcomes)	_____	Current score _____ Initial score _____
☐ Other/No Functional Assessment	_____	Current score _____ Initial score _____
Does your patient demonstrate:	☐ Iliac crest height OR Pubic symphysis asymmetry ☐ Positive provocative S.I. test OR Sacral torsion ☐ INABILITY to perform repetitive contractions of the pelvic floor muscles ☐ INABILITY to relax the pelvic floor muscles ☐ None of the above	
Has pt. responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No (Indicate the reason below)
	N/A – Leave Blank for Initial Request	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program