EviCore
By EVERNORTH

Vestibular Program: PT/OT Therapy Intake Form

Required for all requests

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		
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:			
Date of most initial evaluation:		Date of onset of Condition:	
Date of current findings:			

VESTIBULAR DISORDERS

Condition: Vestibular Disorders ***Please indicate the primary reason for this request:***

- ☐ BPPV (Benign Paroxysmal Positional Vertigo)
- ☐ Vestibular Neuritis
- ☐ Labyrinthitis
- ☐ Post-surgical (labyrinthectomy, acoustic neuroma, etc.)
- ☐ Meniere's disease
- ☐ Other peripheral cause
- ☐ Migraine
- ☐ Stroke
- ☐ Head trauma / Concussion
- ☐ Cerebellar pathology / degeneration
- ☐ Multiple sclerosis
- ☐ Other central cause

Member Name:		Member ID:		Provider Name:	

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

Indicate which patient reported outcome score was used. ☐ None used	**Initial**	**Follow-Up**
☐ Berg Balance Scale	_____ Score (0-56)	_____ Score (0-56)
☐ Tinetti Balance & Gait Assessment	_____ Score (0-28)	_____ Score (0-28)
☐ Timed Up and Go (TUG)	_____ Seconds	_____ Seconds
☐ Dynamic Gait Index	_____ Score (0-24)	_____ Score (0-24)
☐ Dizziness Handicap Inventory	_____ Score (0-100)	_____ Score (0-100)
☐ Activities – specific Balance Confidence Scale (ABC)	_____ Score (0-100)	_____ Score (0-100)
☐ Vertigo Symptom Scale – Short Form (VSS-sf)	_____ Summary Score (0-60)	_____ Summary Score (0-60)
Has pt. responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not responded, lack of patient progress due to (select the most appropriate):	*N/A – Leave Blank for Initial Request*	☐ Progression of symptoms despite treatment ☐ Unable to complete clinical visits/home program