EviCore
By EVERNORTH

Musculoskeletal Program: Home Health/SNF/General Medical PT/OT Clinical Worksheet

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	

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 initial evaluation:	Date of current findings:

Is this request for fabricating a splint/orthotic, instruction in home program, or wheelchair assessment/training ONLY?

☐ No **If no, please continue.**

☐ Yes (Choose one): ☐ HEP ONLY ☐ Splint/Orthotic Fabrication or Training ONLY

☐ Wheelchair Assessment ONLY ☐ Instruction in use of Adaptive Equipment ONLY

If yes, stop here. Additional clinical information is not required

If related to surgery:	Date of Surgery:	Type of Surgery:

Clinical Complexities that will Impact the Therapy Plan of Care Frequency, Intensity, or Duration (Check all that apply)

☐ Diabetes Mellitus ☐ Impaired Cognition/Safety Concerns ☐ Weight Bearing Restrictions

☐ Long COVID/Pulmonary/Cardiac Complexities

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Member Name:		Member ID:		Provider Name:	

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

Functional Status	***Initial***					***Follow-Up***				
0% (Independent/Mod I) 1% to < 20% (Supervision/Contact Guard 20% to < 50% (Minimal Assist) 50% to < 75% (Moderate Assist) 75% to 100% (Maximal Assist/Dependent **For global ratings, choose level that reflects the most difficulty**	O%	1% to <20 %	20% to < 50%	50% to < 75%	75% to 100%	O%	1% to <20 %	20% to < 50%	50% to < 75%	75% to 100%
Occupational Therapy – Complete this section										
Global Prior Level of Function (Required)										
Global Current Level of Function (Required)										
Bathing ☐ Not assessed										
Toileting ☐ Not assessed										
Dressing ☐ Not assessed										
Hygiene/Grooming ☐ Not assessed										
Self-Feeding ☐ Not assessed										
Adaptive Equipment Used	☐ Yes ☐ No					☐ Yes ☐ No				
Physical Therapy – Complete this section	***Initial***					***Follow-Up***				
Global Prior Level of Function (Required)										
Global Current Level of Function (Required)										
Bed Mobility ☐ Not assessed										
Transfers ☐ Not assessed										
Ambulation ☐ Not assessed										
Stairs/Curbs ☐ Not assessed										
Other:	**Distance Walked:** _____ Feet **Device:** ☐ None ☐ Walker ☐ Rolling walker ☐ Crutches ☐ Straight cane ☐ Quad cane ☐ Hemi-walker ☐ Lofstrand crutches					**Distance Walked:** _____ Feet **Device:** ☐ None ☐ Walker ☐ Rolling walker ☐ Crutches ☐ Straight cane ☐ Quad cane ☐ Hemi-walker ☐ Lofstrand crutches				

Occupational and Physical Therapy – Enter Scores for all tests that apply
Physical Performance Testing and Patient Reported Outcomes (Indicate which test was used and enter corresponding score)

☐ None used	**Initial**	**Follow-Up**
☐ 10 Meter Walk Test	_____ Meters/Second	_____ Meters/Second
☐ 30 Second Sit to Stand	_____ Repetitions	_____ Repetitions
☐ Activities –Specific Balance Confidence Scale (ABC)	_____ Score (0-100)	_____ Score (0-100)
☐ Barthel Index	_____ Score (0-100)	_____ Score (0-100)
☐ Berg Balance Scale	_____ Score (0-56)	_____ Score (0-56)
☐ Borg Rating of Perceived Exertion	_____ Score (6-20)	_____ Score (6-20)
☐ DASH/QDASH	_____ Score (0-100)	_____ Score (0-100)
☐ Dynamic Gait Index	_____Score (0-100)	_____Score (0-100)
☐ Elderly Mobility Scale	_____ Score (0-20)	_____ Score (0-20)
☐ Five Times Sit to Stand Test	_____ Seconds	_____ Seconds
☐ Gait Speed	_____ Seconds	_____ Seconds

Member Name:		Member ID:		Provider Name:	

☐ Katz ADL	_____ Score (0-6)	_____ Score (0-6)
☐ MAHC-10 Fall Risk Assessment	_____ Score (0-10)	_____ Score (0-10)
☐ Nine Hole Peg Test	Seconds: (R) _____ (L)_____	Seconds: (R) _____ (L)_____
☐ Six Minute Walk Test	_____ Score	_____ Score
☐ Timed Up and Go (TUG)	_____ Seconds	_____ Seconds
☐ Tinetti Balance & Gait Assessment	_____ Score (0-28)	_____ Score (0-28)

RESPONSE TO CARE		
	Initial	***Follow-Up***
Has patient responded as expected? ☐ Yes ☐ No	*N/A – Leave Blank for Initial Request*	If No, select the reason for lack of progress: ☐ Cognitive impairment ☐ Infection ☐ Recent hospitalization ☐ Ongoing safety concerns/environmental hazards ☐ Progression of symptoms despite treatment ☐ Medical instability ☐ Non-compliance