EviCore
By EVERNORTH

PT/OT Therapy Intake Form: Lymphedema Condition

Required for all Lymphedema 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:			

CLINICAL

Please Indicate cause or problem:

- ☐ Primary Lymphedema (Not related to surgery, radiation treatment, trauma, etc.)
- ☐ Post-Mastectomy secondary lymphedema
- ☐ Secondary lymphedema (No mastectomy)

Indicate Primary Treatment Area(s):

☐ *Lower Quadrant:*	☐ Right OR Left leg	☐ Both legs
☐ *Lower Quadrant:*	☐ Right OR Left arm	☐ Both arms
☐ *Trunk*:	☐ Trunk / Breast	☐ Head / Neck

Member Name:		Member ID:		Provider Name:	

Lymphedema Stage: Please indicate the stage that best describes your patient (***Stage is required***)

- ☐ **Stage 0:** At-risk/subclinical state with no visible peripheral swelling, but symptoms (swelling, heaviness, numbness) may be present.
- ☐ **Stage 1:** Early onset of visible swelling that subsides with elevation. Pitting may be present.
- ☐ **Stage 2:** Consistent volume change with pitting present. Elevation rarely reduces swelling.
- ☐ **Stage 3:** Skin changes (thickening, hyperpigmentation, increased skin folds, etc.) occur. Tissue is fibrotic and pitting is absent.

Are volume measurements available? ☐ Yes ☐ No If yes, please enter below.

If Trunk/Breast or Head/Neck Lymphedema, measurements are not expected

NOTE: If BOTH sides are affected, please enter the RIGHT side volume measurement as the affected side

Affected Side: _____ ml **Other side:** _____ ml

CLINICAL, cont.

Indicate Treatment Phase:

- ☐ Phase 1 - Reductive
- ☐ Phase 2 - Maintenance

Has the patient received a compression garment? ☐ Compression garment received ☐ No garment

For Follow-up requests only: Is the patient responding to treatment as expected? ☐ Yes ☐ No

FOR POST-MASTECTOMY PATIENTS ONLY -

PLEASE INDICATE: Number of visits requested per week: _____ Number of weeks of care: _____