

PT/OT Therapy Intake Form: Neurological Conditions

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: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Street Address: _____ Apt #: _____
	City: _____ State: _____ Zip: _____
	Home Phone: _____ Cell Phone: _____ Primary: <input type="checkbox"/> Home <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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:			
	<i>Code</i>	<i>Description</i>	<i>Code</i>	<i>Description</i>

Start Date for this Request: _____

Date of initial evaluation: _____ Date of onset of condition: _____ Date of current findings: _____

CONDITION: NEUROLOGICAL REHABILITATION

Please indicate the primary condition:

Acquired Brain Injury: <input type="checkbox"/> CVA/ Stroke <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Other acquired injury (e.g. post-surgery, infection)	Neurologic Disease: <input type="checkbox"/> Alzheimer's/ Dementia <input type="checkbox"/> Progressing Muscular Atrophy (ALS, CP, etc.) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis / Guillain-Barré <input type="checkbox"/> Cerebellar Degeneration	Other Neurological Condition: <input type="checkbox"/> Parkinson's Disease/ Syndrome <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Other condition / syndrome
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Is this request for wheelchair / adaptive equipment evaluation / or equipment changes **only**? Yes No

CONDITION: ACQUIRED BRAIN INJURY & NEUROLOGICAL DISEASE

When did the brain injury / condition occur? _____ When was onset of Neurological disease? _____

Has there been an exacerbation/relapsing episode of the condition resulting in change in function? Yes No

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Member Name:	Member ID:	Provider Name:
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CONDITION: SPINAL CORD INJURY
Please enter date of Spinal Cord Injury: _____
Neurologic Level of Injury - _____ Complete <input type="checkbox"/> or Incomplete <input type="checkbox"/>

CONDITION: PARKINSON'S DISEASE
Please indicate the stage (see appendix A): <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five
Does the patient demonstrate any of the following? <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Tremors <input type="checkbox"/> Freezing when walking <input type="checkbox"/> More than one fall in past 3 months <input type="checkbox"/> N/A
Is this request for treatment using the BIG protocol? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your patient participated in a BIG program (in any clinic) in the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your patient had recent deep brain stimulation or other surgical therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT REPORTED/ STANDARDIZED ASSESSMENT		
<i>Complete section below for either initial or follow-up care as appropriate. Authorization for care requires at least one patient reported functional or health test to minimize delay.</i>		
If no patient reported/ standardized assessment was performed, check here: <input type="checkbox"/>		
MOBILITY / BALANCE MEASURES	Initial	Follow-Up (Current Score)
<input type="checkbox"/> Berg Balance Scale	_____ (0-56)	_____ (0-56)
<input type="checkbox"/> Tinetti Balance & Gait Assessment	_____ (0-28)	_____ (0-28)
<input type="checkbox"/> Timed Up and Go (TUG)	_____ seconds	_____ seconds
<input type="checkbox"/> 6 Minute Walk Test	_____ meters OR _____ feet	_____ meters OR _____ feet
<input type="checkbox"/> 10 Meter Walk Test	_____ meters per second (m/s)	_____ meters per second (m/s)
<input type="checkbox"/> Dynamic Gait Index	_____ (0-24)	_____ (0-24)
<input type="checkbox"/> Functional Gait Assessment	_____ (0-30)	_____ (0-30)
<input type="checkbox"/> Functional Reach Test (FRT)	_____ cm	_____ cm
ADL/ DEXTERITY MEASURES	Initial	Follow-Up (Current Score)
<input type="checkbox"/> Nine-Hole Peg Test	Seconds: (R) _____ (L) _____	Seconds: (R) _____ (L) _____
<input type="checkbox"/> Box and Blocks Test	# Blocks: (R) _____ (L) _____	# Blocks: (R) _____ (L) _____
<input type="checkbox"/> Barthel Index	_____ (0-100)	_____ (0-100)
FUNCTIONAL ASSESSMENTS	Initial	Follow-Up (Current Score)
<input type="checkbox"/> SCIM (Spinal Cord Independence Measure)	_____ (0-100)	_____ (0-100)
Has the patient responded as expected?	<i>N/A - Leave Blank for Initial Request</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No (Indicate the reason below)
	<i>N/A - Leave Blank for Initial Request</i>	<input type="checkbox"/> Progression of symptoms despite treatment <input type="checkbox"/> Suffered a new injury resulting in significant change <input type="checkbox"/> Relapse of neurologic condition <input type="checkbox"/> Unable to complete visits/home program <input type="checkbox"/> Other reason for lack of progress

Appendix A: Stages of Parkinson's Disease

- Stage One: Symptoms of PD are mild and only seen on one side of the body (unilateral involvement). Usually minimal or no functional impairment. Symptoms at stage one may include tremor, such as intermittent tremor of one hand, rigidity, or one hand or leg may feel more clumsy than another, or one side of the face may be affected, impacting the expression.
- Stage Two: Considered early disease in PD, characterized by symptoms on both sides of the body (bilateral involvement) or at the midline without impairment to balance. Stage two may develop months or years after stage one. Symptoms may include the loss of facial

Member Name:		Member ID:		Provider Name:	
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expression on both sides of the face, decreased blinking, speech abnormalities, soft voice, monotone voice, fading volume after starting to speak loudly, slurring speech, stiffness or rigidity of the muscles in the trunk that may result in neck or back pain, stooped posture, stooped posture, and general slowness in all activities of daily living. The individual is usually still able to perform tasks of daily living.

- Stage Three: Characterized by loss of balance and slowness of movement. Balance is compromised by the inability to make the rapid, automatic and involuntary adjustments necessary to prevent falling, and falls are common at this stage. Patient is still fully independent in their daily living activities, such as dressing, hygiene, and eating.
- Stage Four: Patient may be able to walk and stand unassisted, but is noticeably incapacitated. Patient is unable to live an independent life and needs assistance with some activities of daily living. The necessity for help with daily living defines this stage. If the patient is still able to live alone, it is still defined as Stage Three.
- Stage Five: Characterized by an inability to rise from a chair or get out of bed without help, may have a tendency to fall when standing or turning, and may freeze or stumble when walking. Around-the-clock assistance is required at this stage to reduce the risk of falling and help the patient with all daily activities.