EviCore
By EVERNORTH

PT/OT Therapy Intake Form: Wound Care

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:	
Is this request for visits for a limited service? ***If no, please continue.***	☐ Yes ☐ No
If Yes, please indicate the service being provided:	☐ Orthotic Fabrication ☐ Compression Garments ☐ Vasopneumatic Pump Training ☐ Limited management of Superficial Wound/Stage 1 Pressure Injury

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

Member Name:		Member ID:		Provider Name:	

CONDITION: WOUND CARE

Please indicate the primary reason for this request: (Choose only one)

☐ **Skin Condition (such as eczema, psoriasis)**

Ulcer:
☐ Diabetic Foot Ulcer
☐ Pressure Injury
☐ Venous Ulcer

☐ **Burn**

☐ **Post-surgical Wound**

☐ **Traumatic wound/other**

PATIENT REPORTED/ STANDARDIZED ASSESSMENT

Complete section below for either initial or follow-up care as appropriate. Please select the Physical Performance test used to assess your patient's condition. Authorization for care requires at least one patient reported functional or health test to minimize delay.

If no patient reported/ standardized assessment was performed, check here: ☐

TEST NAME	Initial	Follow-Up (Current Score)
☐ Bates Jensen Wound Assessment Tool (BWAT)	_____ (13-65)	_____ (13-65)
☐ Cardiff Wound Impact Scale	_____ (0-100)	_____ (0-100)
☐ DESIGN-R	_____ (0-56)	_____ (0-56)
☐ Pressure Ulcer Scale for Healing (PUSH)	_____ (0-56)	_____ (0-56)
☐ Psoriasis Area and Severity Index 75 (PASI 75)	_____ (0-72)	_____ (0-72)
☐ Wagner Grading Scale for Diabetic Ulcers	_____ (0-56)	_____ (0-56)

Are mobility issues being addressed? ☐ Yes ☐ No

CONDITION: ULCER, POST-SURGICAL, TRAUMTIC WOUND/OTHER

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

	Initial	*Follow-Up*
Number of Wounds/Lesions	☐ One ☐ Two ☐ More than Two	☐ One ☐ Two ☐ More than Two
Location of most severe/complex wound	☐ Head/Face ☐ Abdomen ☐ Thigh ☐ Upper back ☐ Upper Arm ☐ Knee ☐ Lower back ☐ Forearm ☐ Calf ☐ Sacrum ☐ Hand/wrist ☐ Foot/ankle	☐ Head/Face ☐ Abdomen ☐ Thigh ☐ Upper back ☐ Upper Arm ☐ Knee ☐ Lower back ☐ Forearm ☐ Calf ☐ Sacrum ☐ Hand/wrist ☐ Foot/ankle
Most severe/complex wound measured in:	☐ Millimeters ☐ Centimeters ☐ Inches	☐ Millimeters ☐ Centimeters ☐ Inches
Size of most severe/complex wound (Length x Width x Depth)	Length _____ Width _____ Depth _____	Length _____ Width _____ Depth _____
Stage (Pressure Injury)	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Un-Stageable ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Un-Stageable ☐ N/A
Depth of most severe/complex wound (use Venous, Diabetic, Traumatic, or Post-Surgical wounds)	☐ Partial Thickness ☐ Full Thickness ☐ N/A	☐ Partial Thickness ☐ Full Thickness ☐ N/A
Tissue Type (Stage most severe/complex wound)	Eschar ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Slough ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Granulation ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Epithelium ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100%	Eschar ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Slough ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Granulation ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100% Epithelium ☐ 0% ☐ 1-24% ☐ 25-49% ☐ 50-74% ☐ 75-99% ☐ 100%
Presence of exudate	☐ None ☐ Scant/Small ☐ Medium ☐ Copious	☐ None ☐ Scant/Small ☐ Medium ☐ Copious
Complexities	☐ Infection ☐ Edema/Lymphedema ☐ No complexities are present	☐ Infection ☐ Edema/Lymphedema ☐ No complexities are present

Member Name:		Member ID:		Provider Name:	

CONDITION: BURN		
Complete the following section for initial or follow-up care as appropriate.		
	Initial	***Follow-Up***
Thermal Injury Classification	☐ Superficial (1st degree) ☐ Superficial-Partial Thickness (2nd degree) ☐ Deep-Partial Thickness (3rd or 4th degree) ☐ Full Thickness (3rd or 4th degree)	☐ Superficial (1st degree) ☐ Superficial-Partial Thickness (2nd degree) ☐ Deep-Partial Thickness (3rd or 4th degree) ☐ Full Thickness (3rd or 4th degree)
Total Body Surface Area Severity	☐ Minor **Adult < 10% TBSA OR Pediatric or Adult 50 years old or greater with < 5% TBSA OR < 2% full thickness** ☐ Moderate **Adult 10%-20% TBSA OR Pediatric or Adult 50 years old or greater with 5%-10% TBSA OR 2%-5% full thickness** ☐ Severe **Adult > 20% TBSA OR Pediatric or Adult 50 years old or greater with > 10% TBSA OR > 5% full thickness**	☐ Minor **Adult < 10% TBSA OR Pediatric or Adult 50 years old or greater with < 5% TBSA OR < 2% full thickness** ☐ Moderate **Adult 10%-20% TBSA OR Pediatric or Adult 50 years old or greater with 5%-10% TBSA OR 2%-5% full thickness** ☐ Severe **Adult > 20% TBSA OR Pediatric or Adult 50 years old or greater with > 10% TBSA OR > 5% full thickness**

RESPONSE TO CARE		
	Initial	***Follow-Up***
Has patient 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 or home program ☐ Medical Instability ☐ Recent hospitalization ☐ Non-compliance ☐ Onset of new infection