Musculoskeletal Program: Chiropractic Intake Form

Required for all Chiropractic 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

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:					

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:

This is a (please select the most appropriate response):

☐ New condition not previously treated ☐ Same/previous condition

Date of most recent evaluation: | Start of care for identified condition:

Date of current findings:

Primary Treatment Area:

Spine:	☐ Cervical / Upper Thoracic Spine	☐ Lower Thoracic / Lumbar / Pelvis	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	
Lower Extremity:	☐ Hip / Thigh	☐ Knee / Thigh	☐ Ankle / Foot / Leg

Secondary Treatment Area:

Spine:	☐ Cervical / Upper Thoracic Spine	☐ Lower Thoracic / Lumbar / Pelvis	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	
Lower Extremity:	☐ Hip / Thigh	☐ Knee / Thigh	☐ Ankle / Foot / Leg

Previous Treatment – Leave Blank if N/A:

If the member requires treatment for a new condition, what was the previous condition? ☐ N/A

☐ Cervical / Upper Thoracic Spine ☐ Lower Thoracic / Lumbar / Pelvis ☐ UE - Shoulder/Arm

☐ UE - Elbow/Wrist/Forearm ☐ LE – Hip/Thigh ☐ LE – Knee/Thigh ☐ LE – Ankle/Foot/Leg

What is the status of the previous treatment? ☐ Condition Resolved ☐ Ongoing Treatment ☐ N/A

Member Name:		Member ID:		Provider Name:	

Please complete the following section(s) based upon the Treatment Area(s) selected above. Information specific to the Primary Treatment Area MUST be completed.

CERVICAL / UPPER THORACIC SPINE

TREATMENT AREA: Cervical / Upper Thoracic Spine		**Request Type:** ☐ Initial ☐ Follow-Up
Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	
Indicate Type of Surgery from Selection Below: ☐ Decompression ☐ Discectomy ☐ Fusion ☐ Total Disc Replacement ☐ Scoliosis/Deformity/Fracture		
Levels of Surgery:		

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

	Initial	***Follow-Up***
Neck Disability Index score (NDI):	% ☐ Not performed	% ☐ Not performed
Radiating pain below elbow:	☐ Yes ☐ No	☐ Yes ☐ No
Number of episodes in past 3 yrs:	☐ 1 ☐ 2 ☐ 3 ☐ ≥4	*N/A – Leave Blank for Follow-Up Request*
Change from previous NDI:	*N/A – Leave Blank for Initial Request*	
Has pt. progressed as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not progressed, lack of patient progress due to (select the most appropriate):	*N/A – Leave Blank for Initial Request*	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program

LOWER THORACIC / LUMBAR / PELVIS

TREATMENT AREA: Lower Thoracic / Lumbar / Pelvis		**Request Type:** ☐ Initial ☐ Follow-Up
Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	
Indicate Type of Surgery from Selection Below: ☐ Decompression ☐ Discectomy ☐ Fusion ☐ Total Disc Replacement ☐ Scoliosis/Deformity/Fracture		
Levels of Surgery:		

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

	Initial	**Follow-Up**
Oswestry Disability Index Score:	% ☐ Not performed	% ☐ Not performed
Radiating Pain to Knee or Below:	☐ Yes ☐ No	☐ Yes ☐ No
Number of episodes in past 3 yrs:	☐ 1 ☐ 2 ☐ 3 ☐ ≥4	*N/A – Leave Blank for Follow-Up Request*
Change from Previous ODI:	*N/A – Leave Blank for Initial Request*	
Has pt. progressed as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not progressed, lack of patient progress due to (select the most appropriate):	*N/A – Leave Blank for Initial Request*	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program

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Member Name:		Member ID:		Provider Name:	

UPPER EXTREMITY (ALL CONDITIONS)

TREATMENT AREA: Upper Extremity (All Conditions)		**Request Type:** ☐ Initial ☐ Follow-Up
Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	

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

	Initial	***Follow-Up***
Assessment Measure Used:	☐ DASH ☐ QuickDASH	☐ DASH ☐ QuickDASH
Function/Symptom Score:	☐ Not performed	☐ Not performed
More than 3 blank answers in DASH or 1 in QuickDash?	☐ Yes ☐ No	*N/A – Leave Blank for Follow-Up Request*
Optional module included?	☐ No ☐ Work ☐ Sports/ Music	☐ No ☐ Work ☐ Sports/Music
Optional Module Score:		
Blank Questions in Optional Module?	☐ Yes ☐ No	☐ Yes ☐ No
Does your patient demonstrate *(choose all that apply)*	☐ Loss of 10 degrees or more of elbow extension ☐ Laxity of the wrist or shoulder ☐ Loss of 30 degrees of shoulder internal or external rotation ☐ Scapula strength measured at 3/5 or less ☐ Measurable (less than 4/5) weakness of shoulder joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension)	
Change from previous DASH:	*N/A – Leave Blank for Initial Request*	
Has patient progressed?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not progressed as expected, lack of patient progress due to (select the most appropriate):	*N/A – Leave Blank for Initial Request*	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program

LOWER EXTREMITY (ALL CONDITIONS)

TREATMENT AREA: Lower Extremity (All Conditions)		**Request Type:** ☐ Initial ☐ Follow-Up
Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	

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

	Initial	**Follow-Up**
Lower Extremity Functional Scale:	☐ Not performed	☐ Not performed
Does your patient demonstrate:	☐ Loss of 10 degrees or more of knee extension ☐ Laxity of the ankle or distal tibial-fibular joint ☐ Measurable (less than 4/5) weakness of hip joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension)	
Change from Previous LEFS:	*N/A – Leave Blank for Initial Request*	
Has pt. progressed as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not progressed, lack of patient progress due to (select the most appropriate):	*N/A – Leave Blank for Initial Request*	☐ "Overdid" activities/exercise causing increase in symptoms ☐ Progression of symptoms despite treatment ☐ Suffered a new injury resulting in significant change ☐ Unable to complete clinical visits/home program

Additional Clinical Information: