FOR EDUCATIONAL PURPOSES ONLY - PLEASE DO NOT SUBMIT THIS FORM

This document is intended to serve as a guide for use and submission of eviCore's Chiropractic Clinical Worksheet. Actual versions of this worksheet that may be submitted to eviCore are available on your Implementation Resource page at www.eviCore.com. Please remember, the **fastest** and most **efficient** way to request authorization for services managed by eviCore is by utilizing our **Provider Web Portal** at https://www.evicore.com/pages/providerlogin.aspx.

If requesting services via fax, please use eviCore's Chiropractic Intake Form. This form has been specifically tailored to collect information needed to perform our clinical review of requested services. Failure to submit this form may result in processing delays.

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

Instruction: Please fill out the below sections. The inputs below will help to identify which fields are required. Please ensure all required fields are completed to avoid potential delays in processing. Completion of these sections will allow us to ensure accurate case build for the requesting provider and patient.

Check boxes indicate fields whereby a selection, per the most appropriate response, is required. Fields labeled as 'Optional' or 'Conditional' should be completed only if applicable.

PATIENT								
First Name:	Required	MI:	*Conditional*	Last Name:	Required			
Member ID:	Required	DOB (mm/dd/yyyy):	Required	Gender:	☐ Male	☐ Female		
Street Address:	Required					Apt #:	*Conditional*	
City:	Required			State:	Required	Zip:	Required	
Home Phone:	*Conditional*	Cell Phone:	*Conditional*	Primary:	☐ Home	☐ Cell		
Member Health Plan/Insurer:	Required							

PROVIDER							
First Name:	Required			Last Name:	Required		
Primary Specialty:	Required	TIN:	Required	NPI:	Required		
Physician Phone:	Required			Physician Fax:	Required		
Address:	Required					Suite #:	*Conditional*
City:	Required			State:	Required	Zip:	Required
Office Contact:	Required	Ext:	Required	Email:	Required		

Instructions continue on next page.

Member Name:		Member ID:		Provider Name:	

Instruction: Please fill out the following section. The inputs below will help to identify which fields are required. Please ensure all required fields are completed to avoid potential delays in processing. Information regarding the patient's primary condition is required.

Check boxes indicate fields whereby a selection, per the most appropriate response, is required. Fields labeled as Optional should be completed as applicable.

ADMINISTRATIVE

Diagnoses:

Code	*Description*
Required	Required
Optional	*Optional*

Code	*Description*
Optional	*Optional*
Optional	*Optional*

Start Date for this Request: Required

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

☐ New condition not previously treated ☐ Same/previous condition

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

Date of current findings: Required

Primary Treatment Area:

Required Selection – Please identify the primary treatment area for which services are being requested. Select one.

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:

Optional selection – Please only complete if previous treatment has been rendered.

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:

Optional selection – Please only complete if previous treatment has been rendered.

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

Required selection – Please indicate applicable response to question below.

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

Instructions continue on next page.

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.

Instruction: The following sections ask clinical questions that are specific to the patient's Primary and Secondary Treatment Areas as identified on page 1 of this Intake Form. The section pertaining to the Primary Treatment Area identified **must** be completed. If a Secondary Treatment Area was also included, the corresponding section is also required.

This section is only required if the Patient's Primary **or** Secondary Treatment Area (from Administrative Section) was identified as the Cervical/Upper Thoracic Spine. Check boxes indicate fields whereby a selection is required, as applicable.

CERVICAL / UPPER THORACIC SPINE

Request type selection below is required. Please indicate if this is an initial request or a follow-up request.

TREATMENT AREA: Cervical / Upper Thoracic Spine | **Request Type:** ☐ Initial ☐ Follow-Up

Please respond to the following questions. The first question, specific to whether or not this request is associated to post-surgical treatment, is required. If yes, the additional fields related to type(s) and level(s) of surgery are also required.

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

Please answer the questions listed within the left side of the grid below. If this request is for the patient's initial treatment, please provide responses below the section labeled "Initial" only. If this request is for follow-up visits, please provide responses in the section labeled "Follow-Up" only.

	Initial *Please answer all questions below for Initial Request*	***Follow-Up*** *Please answer all questions below for Follow-Up Request*
Neck Disability Index score (NDI):	*Conditional* % ☐ Not performed	*Conditional* % ☐ 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*	Required
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

Instructions continue on next page.

Member Name:		Member ID:		Provider Name:	

This section is only required if the Patient's Primary **or** Secondary Treatment Area (from Administrative Section) was identified as the Lower Thoracic/Lumbar/Pelvis. Check boxes indicate fields whereby a selection is required, as applicable.

LOWER THORACIC / LUMBAR / PELVIS

Request type selection below is required. Please indicate if this is an initial request or a follow-up request.

TREATMENT AREA: Lower Thoracic / Lumbar / Pelvis	**Request Type:** ☐ Initial ☐ Follow-Up

Please respond to the following questions. The first question, specific to whether or not this request is associated to post-surgical treatment, is required. If yes, the additional fields related to type(s) and level(s) of surgery are also required.

Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	*Conditional*

Indicate Type of Surgery from Selection Below: *Conditional Selection*

☐ Decompression ☐ Discectomy ☐ Fusion ☐ Total Disc Replacement ☐ Scoliosis/Deformity/Fracture

Levels of Surgery:	*Conditional*

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

	Initial	**Follow-Up**
Oswestry Disability Index Score:	*Conditional* % ☐ Not performed	*Conditional* % ☐ 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*	Required
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

Instructions continue on next page.

Member Name:		Member ID:		Provider Name:	

This section is only required if the Patient's Primary **or** Secondary Treatment Area (from Administrative Section) was identified as any of the Upper Extremity selections. Check boxes indicate fields whereby a selection is required, as applicable.

UPPER EXTREMITY (ALL CONDITIONS)

Request type selection below is required. Please indicate if this is an initial request or a follow-up request.

TREATMENT AREA: Upper Extremity (All Conditions)	**Request Type:** ☐ Initial ☐ Follow-Up

Please respond to the following questions. The first question, specific to whether or not this request is associated to post-surgical treatment, is required. If yes, date of surgery is also required.

Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	*Conditional*

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

Please answer the questions listed within the left side of the grid below. If this request is for the patient's initial treatment, please provide responses below the section labeled "Initial" only. If this request is for follow-up visits, please provide responses in the section labeled "Follow-Up" only.

	Initial *Please answer all questions below for Initial Request*	***Follow-Up*** *Please answer all questions below for Follow-Up Request*
Assessment Measure Used:	☐ DASH ☐ QuickDASH	☐ DASH ☐ QuickDASH
Function/Symptom Score:	*Conditional* ☐ Not performed	*Conditional* ☐ 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:	*Conditional*	*Conditional*
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*	*Required*
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

Instructions continue on next page.

Member Name:		Member ID:		Provider Name:	

This section is only required if the Patient's Primary **or** Secondary Treatment Area (from Administrative Section) was identified as any of the Lower Extremity selections. Check boxes indicate fields whereby a selection is required, as applicable.

LOWER EXTREMITY (ALL CONDITIONS)

Request type selection below is required. Please indicate if this is an initial request or a follow-up request.

TREATMENT AREA: Lower Extremity (All Conditions)	**Request Type:** ☐ Initial ☐ Follow-Up

Please respond to the following questions. The first question, specific to whether or not this request is associated to post-surgical treatment, is required. If yes, date of surgery is also required.

Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*

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

Please answer the questions listed within the left side of the grid below. If this request is for the patient's initial treatment, please provide responses below the section labeled "Initial" only. If this request is for follow-up visits, please provide responses in the section labeled "Follow-Up" only.

	Initial *Please answer all questions below for Initial Request*	***Follow-Up*** *Please answer all questions below for Follow-Up Request*
Lower Extremity Functional Scale:	*Conditional* ☐ Not performed	*Conditional* ☐ 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*	*Required*
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:

Conditional – Please include any other clinical information you would like considered.