

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

	First Name:		MI:		L	ast Name:				
5	Member ID:	(3333)				Gende		Male	☐ Female	
PATIENT	Street Address:							Apt #:		
AT	City:				State:			Zip:		
Ф	Home Phone:	Cell	Phone:				Primar	y: 🗌	Home	☐ Cell
	Member Health Plan/Ins	surer:								
	First Name:			Last Na	me.					
2	Primary Specialty:		TIN:	2401114		N	PI:			
PROVIDER	Physician Phone:			Physicia	an Fax:					
N	Address:			,			Sı	uite #:		
28(City:				Stat	to.		Zi	n·	
_	Office Contact:		Ext		Ota	Emai	Į.		ρ.	
	Omoc Contact.		LX	'		Lina				
	Diameter.									
	Diagnoses:	Description			Codo) o o o wind	···	
	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:									
ш	Date of current findings:	:								
ADMINISTRATIVE	Primary Treatment Are	ea:								
RA	Spine:	Cervical / Upper Thor	racic Spine		ower Th	oracic / Lum	bar / Pe	lvis		
IST	Upper Extremity:	Shoulder / Arm			lbow / V	Vrist / Forea	rm			
Z	Lower Extremity:	Hip / Thigh		□ K	nee / Th	nigh		Ankle	e / Foot / L	eg
NDN	Secondary Treatment	Area:								
1	Spine:	Cervical / Upper Thor	racic Spine		ower Th	oracic / Lum	bar / Pe	lvis		
	Upper Extremity:	Shoulder / Arm				Vrist / Forea				
	Lower Extremity:	Hip / Thigh			nee / Th			Ank	le / Foot / I	_eq
	, ,					3				- 0
	Previous Treatment –	Leave Blank if N/A:								
		treatment for a new cond	dition, what	was the	previous	s condition?		I/A		
	Cervical / Upper	Thoracic Spine	Lower Tho	racic / Lu	mbar / F	Pelvis		□ U	E - Should	er/Arm
	UE - Elbow/Wrist	• —	LE – Hip/T	high		.E – Knee/Th	nigh		E – Ankle/F	oot/Leg
	What is the status of the		Condit			□ Ongoi				

P	lease complete the following secti	on(s) based upon the Treatment Area Primary Treatment Area MUST be co	n(s) selected above. Information specific to the ompleted.			
	TREATMENT AREA: Cerv	vical / Upper Thoracic Spine	Request Type:			
	Post-Surgical Care: Yes	☐ No				
SPINE	Indicate Type of Surgery from Selection Below: Decompression Discectomy Fusion Total Disc Replacement Scoliosis/Deformity/Fracture Levels of Surgery:					
$\frac{3}{5}$,	he following section for initial or follo	w-up care as appropriate			
R A	Oompiete a	Initial	Follow-Up			
우	Neck Disability Index score (NDI):	% Not performed	% Not performed			
F	Radiating pain below elbow:	☐ Yes ☐ No	☐ Yes ☐ No			
EE EE	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	, ,			
/ U	Has pt. progressed as expected?	N/A – Leave Blank for Initial Request	☐ Yes ☐ No			
CERVICAL / UPPER THORACIC	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			
	TREATMENT AREA: Low	er Thoracic / Lumbar / Pelvis	Request Type:			
	Post-Surgical Care: Yes	☐ No If yes, Date of Surgery:				
ဟ	Indicate Type of Surgery from Selection Below:					
⋝	☐ Decompression ☐ Disc	ectomy 🗌 Fusion 🔲 Total Disc F	Replacement Scoliosis/Deformity/Fracture			
Б	Levels of Surgery:					
Decompression Discectomy Fusion Total Disc Replacement Scoliosis/Deformity/Fr Levels of Surgery:						
BA		Initial	Follow-Up			
Ξ	Oswestry Disability Index Score:	% Not performed	% Not performed			
ニ	·		☐ Yes ☐ No			
ပ	Radiating Pain to Knee or Below:					
AC	Number of episodes in past 3 yrs:	<u> </u>	N/A – Leave Blank for Follow-Up Request			
THORACIC	Change from Previous ODI:	N/A – Leave Blank for Initial Request				
Ĭ	Has pt. progressed as expected?	N/A – Leave Blank for Initial Request	☐ Yes ☐ No			
LOWER	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			

Provider Name:

Member ID:

Form Continues on Next Page

Member Name:

Men	nber Name:	Member ID:	Provider Name:						
	TREATMENT AREA: U	oper Extremity (All Conditions)	Request Type:						
	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								
(S	Assessment Measure Used:	☐ DASH ☐ QuickDASH	☐ DASH ☐ QuickDASH						
N	Function/Symptom Score:	☐ Not performed	☐ Not performed						
CONDITIONS	More than 3 blank answers in DASH or 1 in QuickDash?	☐ Yes ☐ No	N/A – Leave Blank for Follow-Up Request						
0	Optional module included?	☐ No ☐ Work ☐ Sports/ Music	☐ No ☐ Work ☐ Sports/Music						
	Optional Module Score:								
EXTREMITY (ALL	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 provious DACH	N/A – Leave Blank for Initial Request	Rotation, Extension)						
JPPER	Change from previous DASH:	<u> </u>	□ Vaa □ Na						
P	Has patient progressed? If patient has not progressed	N/A – Leave Blank for Initial Request	Yes No						
)	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						
<u> </u>	_	ower Extremity (All Conditions)	Request Type: Initial Follow-Up						
SNC	Post-Surgical Care: Yes No If yes, Date of Surgery:								
CONDITIO	Complete the following section for initial or follow-up care as appropriate.								
		Initial	Follow-Up						
ō	Lower Extremity Functional Scal								
(ALL	Lower Extremity Functional Scal	e: Not performed	□ Not performed						
	Does your patient demonstrate:	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-f	ee extension fibular joint ness of hip joint in at least 2 of the following						
	Does your patient demonstrate:	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-f Measurable (less than 4/5) weakned motions (Abduction, Flexion, External Laxity of the ankle or distal tibial-f	ee extension fibular joint ness of hip joint in at least 2 of the following ernal Rotation, Extension)						
	Does your patient demonstrate: Change from Previous LEFS:	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-f Measurable (less than 4/5) weakn motions (Abduction, Flexion, External Request N/A – Leave Blank for Initial Request	ee extension fibular joint ness of hip joint in at least 2 of the following ernal Rotation, Extension)						
	Does your patient demonstrate: Change from Previous LEFS: Has pt. progressed as expected	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-form Measurable (less than 4/5) weaknown motions (Abduction, Flexion, Extension N/A – Leave Blank for Initial Request N/A – Leave Blank for Initial Request	ee extension fibular joint ness of hip joint in at least 2 of the following ernal Rotation, Extension) Yes No						
LOWER EXTREMITY (ALL	Does your patient demonstrate: Change from Previous LEFS:	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-function Measurable (less than 4/5) weaking motions (Abduction, Flexion, Extension N/A – Leave Blank for Initial Request N/A – Leave Blank for Initial Request Review N/A – Leave Blank for Initial Review N/A – L	ee extension fibular joint ness of hip joint in at least 2 of the following ernal Rotation, Extension)						
LOWER EXTREMITY	Does your patient demonstrate: Change from Previous LEFS: Has pt. progressed as expected If patient has not progressed, lac of patient progress due to (selec	Loss of 10 degrees or more of known Laxity of the ankle or distal tibial-function Measurable (less than 4/5) weakned motions (Abduction, Flexion, Externol N/A – Leave Blank for Initial Request N/A – Leave Blank for Initial Request	ee extension fibular joint ness of hip joint in at least 2 of the following ernal Rotation, Extension) Yes No "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						
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