Musculoskeletal Program: PT/OT Therapy Intake Form

Required for all MSK Conditions (Including Hand)

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	

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 (select the most appropriate): ☐ New condition not previously treated ☐ Same/previous condition

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

Primary Treatment Area:

Spine:	☐ Cervical / Upper Thoracic	☐ Lower Thoracic / Lumbar / Pelvis	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	☐ Hand
Lower Extremity:	☐ Hip / Thigh	☐ Knee	☐ Ankle / Foot
Other:	☐ Pelvic Pain / Incontinence		

Secondary Treatment Area:

Spine:	☐ Cervical / Upper Thoracic	☐ Lower Thoracic / Lumbar / Pelvis	
Upper Extremity:	☐ Shoulder / Arm	☐ Elbow / Wrist / Forearm	☐ Hand
Lower Extremity:	☐ Hip / Thigh	☐ Knee	☐ Ankle / Foot
Other:	☐ Pelvic Pain / Incontinence		

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 ☐ Lower Thoracic / Lumbar / Pelvis ☐ UE - Shoulder/Arm ☐ UE - Hand

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

☐ Pelvic Pain / Incontinence

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

Is this request for fabricating a splint/orthotic or developing a home exercise program only? ☐ Yes ☐ No

Member Name:		Member ID:		Provider Name:	

Please ONLY 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

TREATMENT AREA: Cervical / Upper Thoracic		**Request Type:** ☐ Initial ☐ Follow-Up
Post-Surgical Care: ☐ Yes ☐ No	*If yes, Date of Surgery:*	
Surgery Type: ☐ 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. 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*	☐ "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

UPPER EXTREMITY (ALL CONDITIONS)

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

If yes, Indicate Type of Surgery from Selection Below:

Shoulder:	☐ Rotator Cuff ☐ Total Shoulder ☐ Biceps/Slap Repair ☐ Fracture/ORIF ☐ Instability ☐ Sub-Acromial Decompression ☐ MUA
Elbow:	☐ Tendon Repair/Debridement ☐ Total Elbow ☐ Osteochondral ☐ Fracture/ORIF ☐ Ligament Repair ☐ Nerve Release ☐ MUA
Wrist:	☐ Tendon Repair/Debridement ☐ Carpal Tunnel Release ☐ Osteochondral ☐ Fracture/ORIF ☐ Ligament Repair ☐ Nerve Release
Hand:	☐ Nerve Release (Hand) ☐ Ligament Reconstruction (Thumb/Finger) ☐ Fracture/ORIF ☐ Tendon Repair ☐ Finger Joint Replacement ☐ Debridement/Infection

Complete the following section below 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?	☐ Yes ☐ No	*N/A – Leave Blank for Follow-Up Request*
Optional module included?	☐ No ☐ Work ☐ Sports/ Music	☐ No ☐ Work ☐ Sports/ Music
Optional Module Score:		
Shoulder / Elbow: Does your patient demonstrate (*choose all that apply*)	☐ Loss of 15 degrees or more of elbow extension ☐ Recurrent subluxation/dislocation of shoulder ☐ Measurable (less than 4/5) weakness of shoulder joint in at least 2 of the following motions (Abduction, Flexion, External Rotation, Extension) ☐ Fracture of humeral head, greater tubercle, OR olecranon process	
HAND ONLY: Does your patient demonstrate *(choose all that apply)*	☐ Crush injury OR fracture of distal radius or olecranon ☐ Total active range of motion of the thumb less than 100 degrees ☐ Total active range of motion of any other finger less than 130 degrees ☐ Post-surgical or post-traumatic swelling of grade 2 or more (moderate)	
Change from previous DASH:	*N/A – Leave Blank for Initial Request*	
Patient responded as expected?	*N/A – Leave Blank for Initial Request*	☐ Yes ☐ No
If patient has not responded 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

Member Name:		Member ID:		Provider Name:	

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

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:*

Surgery Type: ☐ 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. 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*	☐ "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 | **Sides:** ☐ Left ☐ Right ☐ Bilateral

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

Indicate Type of Surgery from Selection Below:

Knee: ☐ Total/ Partial Arthroplasty ☐ Ligament Reconstruction ☐ Arthroscopy (not ligament) ☐ Fracture ☐ Osteochondral/Microfracture ☐ Tendon Repair ☐ MUA

Hip: ☐ Total/Partial Arthroplasty ☐ Total/Partial Hip Resurfacing ☐ Arthroscopy ☐ Fracture/ORIF ☐ Bursectomy

Ankle/Foot: ☐ Total Ankle Replace ☐ Achilles/Other Tendon Repair ☐ Bunion Surgery ☐ Ligament Reconstruction ☐ Osteochondral/ Microfracture ☐ Fracture/ORIF

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

	Initial	Follow-Up
Identify Functional Test Performed:	☐ LEFS (0-80 score range) ☐ HOOS Jr (0-100 score range) ☐ KOOS Jr (0-100 score range) ☐ None of the Above	☐ LEFS (0-80 score range) ☐ HOOS Jr (0-100 score range) ☐ KOOS Jr (0-100 score range) ☐ None of the Above
Functional Score:	☐ N/A	☐ N/A
Does your patient demonstrate:	☐ Loss of 10 degrees or more of knee extension OR less than 5 degrees of ankle dorsiflexion ☐ Grade 3 or 4 laxity of the ankle or distal tibial-fibular joint ☐ Tinetti Gait/Balance score < 24 OR Berg Balance test < 40 OR TUG test > 13.5 ☐ 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 Score:	*N/A – Leave Blank for Initial Request*	
Has pt. 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*	☐ "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

Member Name:		Member ID:		Provider Name:	

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

Pelvic Pain / Incontinence

TREATMENT AREA: Pelvic Pain / Incontinence		**Request Type:** ☐ Initial ☐ Follow-Up
Complete the following section for initial or follow-up care as appropriate.		
Indicate which patient reported outcome score was used from the selection below. If no score, select "None Used": ☐ None used		
Please enter all component scores	**Initial**	**Follow-Up**
☐ Pelvic Floor Distress Inventory – 20 (PFDI-20).	Summary score (0-300) _____	Summary score (0-300) _____
☐ Pelvic Floor Impact Questionnaire – short form 7 (PFIQ-7).	Summary score (0-300) _____	Summary score (0-300) _____
☐ NIH – Chronic Prostatitis Symptom Index (NIH-CPSI).	Summary score (0-43) _____	Summary score (0-43) _____
☐ Oswestry Disability Index	%	%
Does your patient demonstrate:	☐ Iliac crest height OR Pubic symphysis asymmetry ☐ Positive provocative S.I. test OR Sacral torsion ☐ INABILITY to perform repetitive contractions of the pelvic floor muscles ☐ INABILITY to relax the pelvic floor muscles	
Incontinence *(If applicable)*:	Number of leakage events per day:	*(Enter 0 if not applicable)*
Has pt. 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*	☐ "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: