PT/OT Therapy Intake Form: Lymphedema Condition

Required for all Lymphedema requests

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 (please select the most appropriate response):

☐ New condition not previously treated ☐ Same/previous condition

Date of initial evaluation:		Date of onset of Condition:	
Date of current findings:			
Request Type:	☐ Initial ☐ Follow-Up		

CLINICAL

Please Indicate cause:

☐ Primary Lymphedema (Not related to surgery, radiation treatment, trauma, etc.)
☐ Post-Mastectomy secondary lymphedema
☐ Secondary lymphedema (No mastectomy)

Primary Treatment Area:

☐ *Upper* ☐ *Lower Quadrant:*	☐ Right OR Left side	☐ Both sides
Trunk:	☐ Trunk / Breast	☐ Head / Neck

Lymphedema Stage: Please indicate which stage best describes your patient

☐ **Stage 0:**	At-risk/subclinical state with no visible peripheral swelling, but symptoms (swelling, heaviness, numbness) may be present.
☐ **Stage 1:**	Early onset of visible swelling that subsides with elevation. Pitting may be present.
☐ **Stage 2:**	Consistent volume change with pitting present. Elevation rarely reduces swelling.
☐ **Stage 3:**	Skin changes (thickening, hyperpigmentation, increased skin folds, etc.) occur. Tissue is fibrotic and pitting is absent.

Are volume measurements available? ☐ Yes ☐ No If yes, please enter below.

NOTE: If BOTH sides are affected, please enter the RIGHT side volume measurement as the affected side

Affected Side: _____ ml **Other side:** _____ ml

Member Name:		Member ID:		Provider Name:	

CLINICAL, cont.

Indicate Treatment Phase:

- ☐ Phase 1 - Reductive
- ☐ Phase 2 - Maintenance

Is the patient responding to treatment as expected?	☐ Yes ☐ No
Has the patient received a compression garment?	☐ Compression garment received ☐ No garment

FOR POST-MASTECTOMY PATIENTS ONLY -

PLEASE INDICATE: Number of visits requested per week: _____ Number of weeks of care: _____

Please enter additional relevant functional information for this patient: