

**MIPS FORM**  
**MIPS QUALIFICATION – CLINIC FORM**

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Please answer each of the following questions and return the completed form to the clinic staff.

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** (MM/DD/YYYY) \_\_\_\_\_

**WHAT ARE YOU/THE PATIENT BEING SEEN FOR?**

- NECK OR UPPER BACK (NECK DISABILITY INDEX)**
- SHOULDER OR UPPER ARM (QUICK DASH)**
- ELBOW OR FOREARM (QUICK DASH)**
- WRIST OR HAND (QUICK DASH)**
- MID BACK OR LOWER BACK (MODIFIED OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE)**
- HIP OR THIGH (LOWER EXTREMITY FUNCTIONAL SCALE)**
- KNEE (KNEE OUTCOME SURVEY)**
- LOWER LEG (LOWER EXTREMITY FUNCTIONAL SCALE)**
- ANKLE OR FOOT (LOWER EXTREMITY FUNCTIONAL SCALE)**

**AROUND WHAT DATE DID YOU/THE PATIENT BEGIN EXPERIENCING THIS ISSUE?**

(MM/DD/YYYY) \_\_\_\_\_

**WHAT IS THE PRIMARY PAYER FOR THIS EPISODE?**

- AUTO (EX. ALLSTATE, FARMERS)**
- COMMERCIAL (EX. BCBS, AETNA)**
- INDUSTRIAL (EX. WORKERS' COMP)**
- MEDICARE (EX. PART B, MANAGED MEDICARE PLANS)**
- MEDICAID (EX. CHIP, MANAGED MEDICAID PLANS)**
- SELF PAY**