



CT Maxillofacial and Neck Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax 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.**

Patient/Member	First Name:		Middle Initial:	Last Name:		
	DOB (mm/dd/yyyy):			Gender:	Male	Female
	Street Address:				Apt #:	
	City:			State:	Zip:	
	Home Phone:		Cell Phone:		Primary Contact:	Home Cell
	Health Plan:		Member ID:		Group ID:	
	Ordering Provider	First Name:			Last Name:	
Primary Specialty:		TIN:	NPI:			
Physician Phone:			Physician Fax:			
Address:				Suite #:		
City:			State:	Zip:		
Office Contact:					Ext:	
Contact Email:						
Facility/Site		First Name:			Last Name:	
	Group/Site Name:					
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
	Procedure	Check all applicable CPT Codes:	CT Neck:	70490	70491	70492
CT Maxillofacial:			70486	70487	70488	
Other:						
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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Clinical Information

1. Date of most recent office visit or other contact with physician:		Don't Know		
2. Type of most recent documented contact with physician?				
Hospital	Phone call with office staff			
Office visit	Phone call with physician			
Email	Don't Know			
Other:				
3. Is head or neck cancer suspected?		Yes	No	Don't Know
4. Is there a history of headaches?		Yes	No	Don't Know
5. Is there a history of asthma?		Yes	No	Don't Know
6. Is there a history of chronic sinusitis?		Yes	No	Don't Know
7. Is this a repeat episode of chronic sinusitis?		Yes	No	Don't Know
8. Are there findings of periorbital cellulitis?		Yes	No	Don't Know
9. Has there been failure to improve with physician directed treatment?		Yes	No	Don't Know
10. Has there been failure to improve after a 4 week trial of physician supervised treatment for sinusitis?		Yes	No	Don't Know
11. Was a second antibiotic treatment used if the first course of antibiotic treatment was unsuccessful?		Yes	No	Don't Know
12. Has a specialist evaluation been done?				
Ear Nose and Throat	Neurologist		Other:	
Allergist	Neurosurgeon		Don't Know	
Pulmonologist	No			
13. Is this test to image the spine?		Yes	No	Don't Know
14. Is cancer suspected?		Suspected, not confirmed		Known History
		Not Suspected		Don't Know
15. Is there a neck mass?		Yes	No	Don't Know
16. Is the neck mass painful?		Yes	No	Don't Know
17. Has there been difficulty or pain with swallowing?		N/A	Yes	No
18. Is a thyroid problem suspected?		Yes	No	Don't Know
19. Has a neck ultrasound been:		Done	Planned	Neither
				Don't Know
20. Is neck surgery planned?		Yes	No	Don't Know

Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: