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 auhorization 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:

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
- ◯ Office visit
- ◯ Email
- ◯ Other:
- ◯ Phone call with office staff
- ◯ Phone call with physician
- ◯ Don't Know

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 imrpove after a 4 week trial of physican 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
- ◯ Allergist
- ◯ Pulmonologist
- ◯ Neurologist
- ◯ Neurosurgeon
- ◯ No
- ◯ Other:
- ◯ Don't Know

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	◯ Don't Know
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

Additonal Information/Comments:

Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: