

CT Maxillofacial 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 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 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 used if the first course of antibiotic treatment was unsuccessful?	Yes	No	Don't Know	
12. Has a speical evaluation been done?				
Ear Nose and Throat	Neurologist	Other:		
Allergist	Neurosurgeon	Don't Know		
Pulmonologist	No			
Additonal Information/Comments:				

Submitter	Who is making this request?			Ordering Physician	Facility	Other:	
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:			Date:			