



CT 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 field. **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:	70490	70491	70492		
		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 this test to image the spine?	Yes	No	Don't Know
	4. Is cancer suspected?	Suspected, not confirmed	Known History	
		Not Suspected	Don't Know	
	5. Is there a neck mass?	Yes	No	Don't Know
	6. Is the neck mass painful?	Yes	No	Don't Know
	7. Has there been difficulty or pain with swallowing?	Yes	No	Don't Know
	8. Is a thyroid problem suspected?	Yes	No	Don't Know
9. Has a neck ultrasound been:	Done	Neither		
	Planned	Don't Know		
10. 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:	