



CT Spine 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 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 PHON9.**

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:	C-Spine:	72125	72126	72127		
		T-Spine:	72128	72129	72130		
		L-Spine:	72131	72132	72133	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. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?			
	Date:	This is the first for this episode	Don't Know	
	4. Has a specialist evaluation been performed?			
	5. Did the specialist generate this request?	Yes	No	Don't Know
	6. Has there been a recent head or neck trauma?	Yes	No	Don't Know
	7. In the last two months, has there been significant trauma to the spine involving:			
	A motor vehicle accident (MVA)	A head trauma with loss of consciousness		
	A fall from a height	Other injury:		
	Any fall landing on the head	No injury trauma		
Don't Know				
8. Has there been persistent neck pain since injury?	Yes	No	Don't Know	
9. Is this request for a CT - myelogram or discogram?	Yes	No	Don't Know	
10. Is there an abnormal neurology exam?	Yes	No	Don't Know	
11. Is there a personal history of cancer other than ordinary skin cancer?	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:	