



MRA and CTA Head 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:	MRA HEAD:	70544	70545	70546	
		CTA HEAD:	70496			
		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 there previous head imaging for this problem within the past three years?		Yes	No	Don't Know
4. Date of previous head imaging?		None		Don't Know
5. Has there been recent onset of hemiplegia?		Yes	No	Don't Know
6. Is Dementia or Alzheimer's disease suspected?				
Dementia		Both		
Alzheimer's		Neither		
Don't Know				
7. Has there been a new onset of epileptic seizure?		Yes	No	Don't Know
8. Is there a history of migranes?		Yes	No	Don't Know
9. Has there been persistent unresponsive vertigo despite several days of treatment?		Yes	No	Don't Know
10. Has a trial of physician-directed treatment been completed?		Yes	No	Don't Know
11. Has physician-directed treatment been completed?		Yes	No	Don't Know
12. When did treatment start?				
Less than 1 month ago		No Treatment		
More than 1 month ago		Does Not Apply		
Don't Know				
13. Can the patient walk normally?		Yes	No	Don't Know
14. Is there a known brain tumor?		Yes	No	Don't Know
15. Has there been a known (not suspected) recent stroke or TIA?		Yes	No	Don't Know
16. Is there a family history of 1st degree relatives with a brain aneurysm?		Yes	No	Don't Know
17. Is there a previous MRI or CT head imaging for this problem?		Yes	No	Don't Know
18. Has there been a recent evaluation by a neurologist or neurosurgeon?		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: