

## MRA/CTA Head 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. Requests may also be submitted via the web at eviCore.com. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE TO 800.440.5071.**

<b>Patient/Member</b>	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:				
<b>Ordering Provider</b>	First Name:		Last Name:		Medicaid ID:		
	Primary Specialty:		TIN:	NPI:			
	Physician Phone:			Physician Fax:			
	Address:				Suite #:		
	City:			State:	Zip:		
	Office Contact:				Ext:		
	Contact Email:						
<b>Facility/Site</b>	First Name:			Last Name:			
	Group/Site Name:			Medicaid ID:			
	Primary Specialty:		TIN:	NPI:			
	Site Phone:			Site Fax:			
	Address:				Suite #:		
	City:			State:	Zip:		
<b>Procedure</b>	Check all applicable CPT Codes:	CTA HEAD/NECK:	70496	70498			
		MRA HEAD:	70544	70545	70546		
		MRA NECK:	70547	70548	70549	Other:	
<b>Diagnosis</b>	Diagnosis, if known or rule out:						
	ICD-10 Codes:						
	Date of last visit:						

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<b>Clinical Information</b>	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. Has there been a known (not suspected) recent stroke or TIA?	Yes	No	Don't Know
	4. Is there a family history of 1st degree relatives with a brain aneurysm?	Yes	No	Don't Know
5. Is there previous MRI CT head imaging for this problem?	Yes	No	Don't Know	
6. Has there been a recent evaluation by a neurologist or neurosurgeon?	Yes	No	Don't Know	
Additional Information/Comments:				

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