MRI Abdomen and Pelvis Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. to 888.693.3210. 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.**

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:	

Ordering Provider

First Name:	Last Name:	Medicaid ID:
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:	Medicaid ID:	
Primary Specialty:	TIN:	NPI:
Site Phone:	Site Fax:	
Address:		Suite #:
City:	State:	Zip:

Procedure

Check all applicable CPT Codes:	MRI Abdomen:	☐ 74181	☐ 74182	☐ 74183
	MRI Pelvis:	☐ 72195	☐ 72196	☐ 72197
	☐ Other:			

Diagnosis

Diagnosis, if known or rule out:
ICD-10 Codes:
Date of last visit:

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 ◯ Office visit ◯ Email ◯ Other:	◯ Phone call with office staff ◯ Phone call with physician ◯ Don't Know		
3. Is there a reason to avoid CT contrast (allergy to contrast material or renal failure)?	◯ Yes	◯ No	◯ Don't Know
4. Is a lipoma suspected?	◯ Yes	◯ No	◯ Don't Know
5. Are there unclear findings on previous ultrasound?	◯ Yes	◯ No	◯ Don't Know
6. Is there a current pregnancy?	◯ Yes	◯ No	◯ Don't Know
7. Is this for right lower quadrant pain with associated fever?	◯ Yes	◯ No	◯ Don't Know
8. Is this to evaluate for causes of hematura?	◯ Yes	◯ No	◯ Don't Know
9. Is pain present?	◯ Yes	◯ No	◯ Don't Know
10. Are there unclear findings in previous CT-Abdomen imaging?	◯ Yes	◯ No	◯ Don't Know
11. Is this for right upper quadrant pain associated with fever?	◯ Yes	◯ No	◯ Don't Know
12. Is jaundice present?	◯ Yes	◯ No	◯ Don't Know
13. Is the AFP elevated?	◯ Yes	◯ No	◯ Don't Know
14. Is the study to evaluate liver lesion?	◯ Yes	◯ No	◯ Don't Know
15. Are there unclear findings in previous CT-Pelvic imaging?	◯ Yes	◯ No	◯ Don't Know
16. Is this for pre or post surgery?	◯ Yes	◯ No	◯ Don't Know
17. Is a UAE planned? (Uterine Artery Embolization is an invasive procedure to treat fibroids)	◯ Yes	◯ No	◯ Don't Know
18. Has a UAE been completed within the last 6 months?	◯ Yes	◯ No	◯ Don't Know
19. Is abnormal uterine or vaginal bleeding present?	◯ Yes	◯ No	◯ Don't Know
20. Has there been a period of conservative treatment (Birth control pills or hormones)?	◯ 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: