MRI LE and UE Joint 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 UE Joint:	☐ 73221	☐ 73222	☐ 73223
	MRI LE Joint:	☐ 73721	☐ 73722	☐ 73723
	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. What was the date of the FIRST office visit for this episode of symptoms (shoulder pain, knee pain, etc.)?

Date: ◯ This is the first visit for this episode ◯ Don't Know

4. Has a specialist evaluation been completed?	◯ Yes	◯ No	◯ Don't Know
5. Has there been a recent injury?	◯ Yes	◯ No	◯ Don't Know
6. Has an X-ray been done?	◯ Yes	◯ No	◯ Don't Know
7. Is there a personal history of cancer other than ordinary skin cancer?	◯ Yes	◯ No	◯ Don't Know
8. Is this study to evaluate arthritis?	◯ Yes	◯ No	◯ Don't Know

9. What is the range of motion? ◯ Full Motion ◯ Limited/Painful ◯ Don't Know

10. Has there been a period of conservative treatment?

- ◯ 3 weeks or less
- ◯ 4 weeks
- ◯ 6 weeks
- ◯ 8 or more weeks
- ◯ No Treatment
- ◯ Don't Know

11. Indicate type of physician directed treatment (select all that apply):

- ◯ N-S-A-I-D-S (Nonsteroidal anti-inflammatory drugs) and/or oral steroids
- ◯ Steroid injections
- ◯ Home exercise or physical therapy (PT)
- ◯ Pain medication other than N-S-A-I-D-S
- ◯ Splinting/Bracing
- ◯ Other:
- ◯ No Treatment
- ◯ 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: