# MRI and CT - Head and CT Neck 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:

| | | | | |
|---|---|---|---|---|
| CT NECK: | ☐ 70490 | ☐ 70491 | ☐ 70492 | |
| MRI HEAD: | ☐ 70336 | ☐ 70540 | ☐ 70542 | ☐ 70543 |
| | ☐ 70551 | ☐ 70552 | ☐ 70553 | |
| CT HEAD: | ☐ 70450 | ☐ 70460 | ☐ 70470 | ☐ 70496 |
| | ☐ 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 this test to image the spine? ◯ Yes ◯ No ◯ Don't Know

4. Is cancer suspected?

- ◯ Suspected, not confirmed
- ◯ Not suspected
- ◯ Known history
- ◯ Don't Know

5. Is there a neck mass? ◯ Yes ◯ No ◯ Don't Know

6. Is the neck mass painful? ◯ Yes ◯ No ◯ Don't Know

7. Has there been difficulty or pain with swallowing? ◯ Yes ◯ No ◯ Don't Know

8. Is a thyroid problem suspected? ◯ Yes ◯ No ◯ Don't Know

9. Has a neck ultrasound been:

- ◯ Done
- ◯ Planned
- ◯ Neither
- ◯ Don't Know

10. Is neck surgery planned? ◯ Yes ◯ No ◯ Don't Know

11. Is there previous head imaging for this problem within the past three years? ◯ Yes ◯ No ◯ Don't Know

12. Date of previous head imaging?

- ◯ None
- ◯ Don't Know
- Other:

13. Has there been a recent onset of hemiplegia? ◯ Yes ◯ No ◯ Don't Know

14. Is Dementia or Alzheimer's disease suspected?

- ◯ Dementia
- ◯ Alzheimer's
- ◯ Both
- ◯ Neither
- ◯ Don't Know

15. Has there been a new onset of epileptic seizure? ◯ Yes ◯ No ◯ Don't Know

16. Is there a history of migranes? ◯ Yes ◯ No ◯ Don't Know

## Clinical Information

| | | | |
|---|---|---|---|
| 17. Has there been persistent unresponsive vertigo despite several days of treatment? | Yes | No | Don't Know |
| 18. Has a trial of physician-directed treatment been completed? | Yes | No | Don't Know |
| 19. Has physician-directed treatment of at least 3 weeks failed to help the problem? | Yes | No | Don't Know |

20. When did treatment start?

- Less than 1 month ago
- More than 1 month ago
- Don't Know
- No Treatment
- Does Not Apply

| | | | |
|---|---|---|---|
| 21. Can the patient walk normally? | Yes | No | Don't Know |
| 22. Is there a known brain tumor? | 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: