

MRI and CT Head and MRI Spine 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: (866) 455-4545**

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:		Tax 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:	C-Spine:		72141	72142	72156
		T-Spine:		72146	72147	72157
		L-Spine:		72148	72149	72158
		MRI Head:		70551	70552	70553
		CT Head:		70450	70460	70470

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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	Phone call with office staff		
	Office visit	Phone call with physician		
	Email	Don't know		
	Other			
	3. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?			
	Date:			
	This is the first visit for this episode		Don't Know	
	4. Is there a previous imaging for this problem within the past 6 months?			
	Suspected, not confirmed		Known History	
Not Suspected		Don't Know		
5. Is there a personal history of cancer other than ordinary skin cancer?				
		Yes	No	Don't Know
6. Has there been a failure to improve with physician directed treatment?				
4 weeks or less		8 or more weeks		
6 weeks		No Treatment		
Don't Know				
7. In the last two months, has there been significant trauma to the spine involving:				
A motor vehicle accident (MVA)		No injury or trauma		
Any fall landing on the head		Other injury:		
A fall from a height		Don't Know		
A head trauma with loss of consciousness				
8. Is the imaging request related to back or neck pain?				
		Yes	No	Don't Know
9. Is there previous head imaging for this problem within the past three years?				
		Yes	No	Don't Know
10. Date of previous head imaging?				
Don't Know		Other:		
		None		
11. Has there been recent onset of hemiplegia?				
		Yes	No	Don't Know

Clinical Information

12. Is Dementia or Alzheimer's disease suspected?				
Dementia		Both		
Alzheimer's		Neither		
Don't Know				
13. Has there been a new onset of epileptic seizure?		Yes	No	Don't Know
14. Is there a history of migraines?		Yes	No	Don't Know
15. Has there been persistent unresponsive vertigo despite several days of treatment?		Yes	No	Don't Know
16. Has a trial of physician-directed treatment been completed?		Yes	No	Don't Know
17. Has physician-directed treatment of at least 3 weeks failed to help the problem?		Yes	No	Don't Know
18. When did treatment start?				
Less than 1 month ago		No Treatment		
More than 1 month ago		Does Not Apply		
Don't Know				
19. Can the patient walk normally?		Yes	No	Don't Know
20. Is there a known brain tumor?		Yes	No	Don't Know
Additional Information/Comments:				

Submitter

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