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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 HC:, \$\$"((\$") \$+%"

| Patient/Member | First Name: | | Middle Initial: | Last Name: | ame: | | | |
|-------------------|---|--|-----------------|---|------------------------------------|--------|--|--|
| | DOB (<i>mm/dd/yyyy</i>): | | Gender: | Male | Female | | | |
| | Street Address: | | | | Apt #: | | | |
| | City: | | | State: | Zip: | | | |
| | Home Phone: | | Cell Phone: | | Primary Contact: Home Cell | | | |
| | Health Plan: | | Member ID: | | | | | |
| ider | First Name: | | Last Name: | | Medicaid ID: | | | |
| | Primary Specialty: | | TIN: | | NPI: | | | |
| o | Physician Phone: | | | Physician Fax | sician Fax: | | | |
| P B | Address: | | | | Suite #: | | | |
| Ordering Provider | City: | | | State: | Zip: | | | |
| | Office Contact: | | | | | Ext: | | |
| | Contact Email: | | | | | | | |
| | First Name: | | | Last Name: | | | | |
| | riist ivaille. | | | Last Name. | | | | |
| ite | Group/Site Nam | e: | | Medicaid ID: | | | | |
| ty/Site | | | TIN: | | NPI: | | | |
| cility/Site | Group/Site Nam | | TIN: | | NPI: | | | |
| Facility/Site | Group/Site Nam | | TIN: | Medicaid ID: | NPI: Suite #: | | | |
| Facility/Site | Group/Site Nam Primary Special Site Phone: | | TIN: | Medicaid ID: | I | | | |
| | Group/Site Nam Primary Special Site Phone: Address: City: | | | Medicaid ID: Site Fax: | Suite #: | | | |
| dure | Group/Site Nam Primary Specials Site Phone: Address: City: Check all- applicable | ty: | 72141 | Medicaid ID: Site Fax: State: | Suite #: Zip: | | | |
| | Group/Site Nam Primary Special Site Phone: Address: City: Check all | MRI C-Spine: | 72141 72146 | Medicaid ID: Site Fax: State: 72142 | Suite #: Zip: 72156 | Other: | | |
| Procedure | Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable CPT Codes: | MRI C-Spine: MRI T-Spine: | 72141 72146 | Medicaid ID: Site Fax: State: 72142 72147 | Suite #: Zip: 72156 72157 | Other: | | |
| dure | Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable CPT Codes: | MRI C-Spine: MRI T-Spine: MRI L-Spine: | 72141 72146 | Medicaid ID: Site Fax: State: 72142 72147 | Suite #: Zip: 72156 72157 | Other: | | |

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| Is this request to rule out or evaluate any of the following | ? Choose the primary reason only. | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Multiple Sclerosis (This is the incorrect fax form. Please use the MIR Spine - Multiple Sclerosis fax form) | Please use the MIR Spine - Multiple Sclerosis fax incorrect fax form. Please use the MRI Spi | | | | | | | |
| Back/Neck Pain | Surgical Planning/Pre-op | | | | | | | |
| Metastatic Cancer | Don't Know | | | | | | | |
| None of the Above (enter reason in comment section | None of the Above (enter reason in comment section at the end of the survey) | | | | | | | |
| 2. Provide the following dates: | Provide the following dates: | | | | | | | |
| Date of the first office visit with any physician for this | s episode: Don't Kno | | | | | | | |
| Date of the most recent office visit for this episode: | Don't Kno | | | | | | | |
| 3. What are the current symptoms? Choose all that apply. | 3. What are the current symptoms? Choose all that apply. | | | | | | | |
| No symptoms | Leg pain that goes below the knee | | | | | | | |
| Lower back pain | Upper back pain | | | | | | | |
| Hip or thigh pain | Arm pain that goes into forearm or hand | | | | | | | |
| Neck pain | None of the above | | | | | | | |
| Don't Know | | | | | | | | |
| 4. How long has there been physician-directed treatment or observation since the onset of the episode? (Physician directed treatment might include pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home excercise program) | | | | | | | | |
| No physician directed treatment | Six weeks | | | | | | | |
| Three weeks or fewer | Seven weeks | | | | | | | |
| Four weeks | Eight weeks or more | | | | | | | |
| Five weeks | Don't Know | | | | | | | |
| 5. How have symptoms changed with physician directed treatment or observation? (Physician directed treatment might include the following: pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program.) | | | | | | | | |
| No physician directed treatment or observation | Symtoms have worsened | | | | | | | |
| Symptoms have improved | Don't Know | | | | | | | |
| II . | | | | | | | | |

| | 6. Were any of the following found by a medical professional on a physical exam performed for this episode? Choose all that apply. | | | | | | |
|----------------------|--|--|--------|----|-------------|--|--|
| | No physical exam performed | Foot drop | | | | | |
| | Upper motor neuron signs (Hoffman's, Babinski, Hyperreflexia) | Muscle strength four out of five or less in one or both arms documented on the exam by the physician | | | | | |
| | Decreased reflexes in upper extremity(ies) | Muscle strength four out of five or less in one or both legs documented on the exam by the physician | | | | | |
| | Decreased reflexes in lower extremity(ies) | None of the above | | | | | |
| | Incontinence of bowel/bladder | Don't Know | | | | | |
| | 7. Are any of the following present in the medical history? Choo | se all that apply | y. | | | | |
| Clinical Information | Cancer that has been treated within the last ten years other than squamous (skwā-məs) or basal (bā-səl) cell skin cancer | Immunosuppression (Hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis) | | | | | |
| | Back surgery or cervical spine surgery | IV drug use | | | | | |
| | None of the above | Don't Know | | | | | |
| | 8. Has a CT or MRI of the cervical spine been performed within six months? | the last | Yes | No | Don't Know | | |
| | Has a CT or MRI of the thoracic spine been performed within six months? | the last | Yes | No | Don't Know | | |
| | 10. Has a CT or MRI of the lumbar spine been performed within six months? | the last | Yes | No | Don't Know | | |
| | Additonal Information/Comments: | | | | | | |
| | | | | | | | |
| | Who is making this request? Ordering Physician F | acility (| Other: | | | | |
| Submitter | Print Name: | | | | | | |
| | Title: MD RN LPN PA NP Other: | | | | | | |
| <i>(</i>) | Signature: | Dء | ate: | | | | |
| | | | | | Page 3 of 3 | | |