MRI Spine - Evauluate Neck/Back Pain 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 C-Spine:	☐ 72141	☐ 72142	☐ 72156				
	MRI T-Spine:	☐ 72146	☐ 72147	☐ 72157				
	MRI L-Spine:	☐ 72148	☐ 72149	☐ 72158	☐ Other:			

Diagnosis

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

Clinical Information

1. 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)
- ◯ Known or Suspected Spine Trauma (This is the incorrect fax form. Please use the MRI Spine - Trauma fax form)
- ◯ Back/Neck Pain
- ◯ Surgical Planning/Pre-op
- ◯ Metastatic Cancer
- ◯ Don't Know
- ◯ None of the Above (enter reason in comment section at the end of the survey)

2. Provide the following dates:

Date of the first office visit with any physician for this episode: ◯ Don't Know

Date of the most recent office visit for this episode: ◯ Don't Know

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
- ◯ Symptoms have stayed the same

Clinical Information

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
- ◯ Upper motor neuron signs (Hoffman's, Babinski, Hyperreflexia)
- ◯ Decreased reflexes in upper extremity(ies)
- ◯ Decreased reflexes in lower extremity(ies)
- ◯ Incontinence of bowel/bladder
- ◯ Foot drop
- ◯ Muscle strength four out of five or less in one or both arms documented on the exam by the physician
- ◯ Muscle strength four out of five or less in one or both legs documented on the exam by the physician
- ◯ None of the above
- ◯ Don't Know

7. Are any of the following present in the medical history? Choose all that apply.

- ◯ Cancer that has been treated within the last ten years other than squamous (skwā-məs) or basal (bā-səl) cell skin cancer
- ◯ Back surgery or cervical spine surgery
- ◯ None of the above
- ◯ Immunosuppression (Hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis)
- ◯ IV drug use
- ◯ Don't Know

8. Has a CT or MRI of the cervical spine been performed within the last six months? ◯ Yes ◯ No ◯ Don't Know

9. Has a CT or MRI of the thoracic spine been performed within the last six months? ◯ Yes ◯ No ◯ Don't Know

10. Has a CT or MRI of the lumbar spine been performed within the last six months? ◯ 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: