MRI Spine - Multiple Sclerosis 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:

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Clinical Information

1. Is this request to rule out or evaluate any of the following? Please choose only the primary reason.

- ◯ Back/neck pain (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back Pain Fax Form)
- ◯ Multiple Sclerosis
- ◯ Known or suspected spine trauma (This is the incorrect fax form. Please use MRI Spine – Trauma Fax Form)
- ◯ Metastatic cancer (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back Pain Fax Form)
- ◯ Surgical planning/Pre-op (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back Pain Fax Form)
- ◯ None of the above (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back Pain Fax Form)
- ◯ Don’t Know (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back Pain Fax Form)

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. Is this request for suspected or confirmed (established) MS?

- ◯ Suspected
- ◯ Established
- ◯ Don't Know

4. If MS is a confirmed (established) diagnosis, is immunotherapy currently being used? (Immunotherapy may consist of Copaxone®, Tysabri®, Novantrone® or beta-interferons such as Avonex®, Betaseron® or Rebif®)

- ◯ No, this is for suspected MS
- ◯ Confirmed MS with use of immnotherapy
- ◯ Confirmed MS, not currently using immunotherapy

5. Have any of the following neurological deficits occurred in the past month? Choose all that apply.

- ◯ Sensory problems (Loss of function or sensation to one side of the body, tingling or shooting pain)
- ◯ Bowel or bladder problems
- ◯ Hemiparesis ([hem-ee-puh-ree-sis], muscular weakness of one half of the body)
- ◯ Gait or balance problems (Gait refers to the way or style of walking)
- ◯ Vision disturbances (Double vision, loss of vision, etc.)
- ◯ Other:
- ◯ 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: