



MRI Spine - Known or Suspected Spine Trauma 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 (<i>mm/dd/yyyy</i>):		Gender:	Male	Female			
	Street Address:				Apt #:			
	City:		State:	Zip:				
	Home Phone:		Cell Phone:		Primary Contact: Home Cell		Cell	
	Health Plan:		Member ID:					
Ordering Provider	First Name:		Last Name:		Medicaid ID:			
	Primary Specialty:		TIN:		NPI:			
	Physician Phone	e:		Physician Fax	an Fax:			
	Address:				Suite #:			
erir	City:			State:	Zip:			
Drde	Office Contact:					Ext:		
Ŭ	Contact Email:							
-								
	First Name:			Last Name:				
ite	First Name: Group/Site Nam	ne:		Last Name: Medicaid ID:				
ty/Site			TIN:		NPI:			
cility/Site	Group/Site Nam		TIN:		NPI:			
Facility/Site	Group/Site Nam Primary Special		TIN:	Medicaid ID:	NPI: Suite #:			
Facility/Site	Group/Site Nam Primary Special Site Phone:		TIN:	Medicaid ID:	1			
	Group/Site Nam Primary Special Site Phone: Address: City:			Medicaid ID: Site Fax:	Suite #:			
dure	Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable	lty:	72141	Medicaid ID: Site Fax: State:	Suite #: Zip:			
	Group/Site Nam Primary Special Site Phone: Address: City: Check all	lty: 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:	lty: 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:	Ity: MRI C-Spine: MRI T-Spine: MRI L-Spine: nown or rule out:	72141 72146	Medicaid ID: Site Fax: State: 72142 72147	Suite #: Zip: 72156 72157	Other:		

CONFIDENTIALITY NOTICE: This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information is intended only for the use of the recipient (s) named above. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify eviCore healthcare and destroy the original transmission and its attachments without saving them in any manner.

	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)				
Clinical Information	Multiple Sclerosis (This is the incorrect fax form. Please use MRI Spine - Multiple Sclerosis Fax Form)				
	Known or suspected spine trauma				
	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 t	his episode: Don't Know			
	Date of the most recent office visit for this episode	e: Don't Know			
	3. Has there been a history of spine trauma from any of the following?				
	No injury or trauma	Diving accident (diving board, cliff diving, etc.)			
	Motor Vehicle Accident (MVA)	Strain from lifting, turning head, minor fall			
	Fall from height over 3 feet or 5 stairs	None of the above			
	Head trauma with loss of consciousness	Don't Know			
	4. When did the spine trauma occur?				
	No injury or trauma	Greater than three months ago			
	Less than a month ago	Don't Know			
	One to three months ago				
	5. What are the current symptoms? (Choose all that apply)				
	No symptoms	Leg pain that goes below the knee			
	Lower back pain	Upper back pain (middle or upper back)			
	Hip or thigh pain	Arm pain that goes into forearm or hand			
	Neck pain	None of the above			
	Don't Know				

	6 How long has there been physician directed treatments	r observation since the enset of this enjected (Dhusisian			
	6. How long has there been physician-directed treatment or observation since the onset of this episode? (Physician directed treatment might include pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program)				
Clinical Information	No physician directed treatment	Six weeks			
	Three weeks or fewer	Seven weeks			
	Four weeks	Eight weeks or more			
	Five weeks	Don't Know			
	7. How have symptoms changed with physician directed treatment or observation? (Physician directed treatment might include pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program)				
	No physician directed treatment or observation	Symptoms have worsened			
	Symptoms have improved	Don't Know			
	Symptoms have stayed the same				
	8. 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			
	9. 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	Immunosuppression (hover hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis)			
	Cervical Spine Surgery	IV drug use			
	Thoracic Spine Surgery	None of the above			
	Lumbar Spine Surgery	Don't Know			
	10. Has a CT or MRI of the cervical spine been performed since the initial spine trauma?				
	No CT or MRI of the cervical spine has been performed	None of the above			
	Cervical Spine CT	Don't Know			
	Cervical Spine MRI				

	11. If plain x-rays of the spine were performed for the trauma, what were the results?					
	No plain x-rays were performed	New fracture of thoracic spine				
	Normal	New fracture of lumbar spine				
	Degenerative disc disease	None of the above				
	New fracture of cervical spine	Don't Know				
	Additonal Information/Comments:					
Clinical Information						
	Who is making this request? Ordering Physician	Facility Other:				
Submitter	Print Name:					
	Title: MD RN LPN PA NP Other:					
	Signature:	Date:				