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 (*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? 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 (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 this episode: ◯ Don't Know

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

3. Has there been a history of spine trauma from any of the following?

- ◯ No injury or trauma
- ◯ Motor Vehicle Accident (MVA)
- ◯ Fall from height over 3 feet or 5 stairs
- ◯ Head trauma with loss of consciousness
- ◯ Diving accident (diving board, cliff diving, etc.)
- ◯ Strain from lifting, turning head, minor fall
- ◯ None of the above
- ◯ Don't Know

4. When did the spine trauma occur?

- ◯ No injury or trauma
- ◯ Less than a month ago
- ◯ One to three months ago
- ◯ Greater than three months ago
- ◯ Don't Know

5. What are the current symptoms? (Choose all that apply)

- ◯ No symptoms
- ◯ Lower back pain
- ◯ Hip or thigh pain
- ◯ Neck pain
- ◯ Don't Know
- ◯ Leg pain that goes below the knee
- ◯ Upper back pain (middle or upper back)
- ◯ Arm pain that goes into forearm or hand
- ◯ None of the above

Clinical Information

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)

- ◯ No physician directed treatment
- ◯ Three weeks or fewer
- ◯ Four weeks
- ◯ Five weeks
- ◯ Six weeks
- ◯ Seven weeks
- ◯ Eight weeks or more
- ◯ 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 improved
- ◯ Symptoms have stayed the same
- ◯ Symptoms have worsened
- ◯ Don't Know

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
- ◯ 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

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
- ◯ Cervical Spine Surgery
- ◯ Thoracic Spine Surgery
- ◯ Lumbar Spine Surgery
- ◯ Immunosuppression (hover hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis)
- ◯ IV drug use
- ◯ None of the above
- ◯ 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
- ◯ Cervical Spine CT
- ◯ Cervical Spine MRI
- ◯ None of the above
- ◯ Don't Know

Clinical Information

11. If plain x-rays of the spine were performed for the trauma, what were the results?

- ◯ No plain x-rays were performed
- ◯ Normal
- ◯ Degenerative disc disease
- ◯ New fracture of cervical spine
- ◯ New fracture of thoracic spine
- ◯ New fracture of lumbar spine
- ◯ None of the above
- ◯ 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: