MRI Knee Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. 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. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

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:	Group ID:

Ordering Provider

First Name:		Last Name:
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:		
Primary Specialty:	TIN:	NPI:
Site Phone:		Site Fax:
Address:		Suite #:
City:	State:	Zip:

Procedure

Check all applicable CPT Codes:	MRI Knee: ☐ 73721 ☐ 73722 ☐ 73723
	Other:

Diagnosis

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

Clinical Information

1. Date of most recent office visit or other contact with physician: ☐ Don't Know

2. Type of most recent documented contact with physician?

- ○ Hospital
- ○ Office visit
- ○ Email
- ○ Other:
- ○ Phone call with office staff
- ○ Phone call with physician
- ○ Don't Know

3. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?

Date: ○ This is the first visit for this episode ○ Don't Know

4. Has a specialist evaluation been completed?

- ○ Orthopedist
- ○ Podiatrist
- ○ Don't Know
- ○ Sports Medicine
- ○ No

5. Has there been a recent injury?

- ○ Within the past two months
- ○ More than two months
- ○ No
- ○ Don't Know

6. Has an X-ray been done?	○ Yes	○ No	○ Don't Know
7. Is there a personal history of cancer other than ordinary skin cancer?	○ Yes	○ No	○ Don't Know
8. Is this study to evaluate arthritis?	○ Yes	○ No	○ Don't Know
9. Are the knee ligaments stable upon examination?	○ Yes	○ No	○ Don't Know
10. Is there a positive McMurray test?	○ Yes	○ No	○ Don't Know
11. Does the knee have full extension upon examination?	○ Yes	○ No	○ Don't Know

12. Has there been a period of conservative treatment?

- ○ 3 weeks or less
- ○ 4 weeks
- ○ 6 weeks
- ○ 8 or more weeks
- ○ None
- ○ Don't Know

13. Indicate type of physician directed treatment (select all that apply):

- ○ N-S-A-I-D-S (Nonsteroidal anti-inflammatory drugs) and/or oral steroids
- ○ Steroid injections
- ○ Home exercise or physical therapy (PT)
- ○ Pain medication other than N-S-A-I-D-S
- ○ Splinting/Bracing
- ○ Other:
- ○ No Treatment
- ○ 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:

eviCore healthcare | www.eviCore.com | 400 Buckwalter Place Blvd • Bluffton, SC • 29910 | 800.918.8924