



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:					

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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		Phone call with office staff		
Office visit		Phone call with physician		
Email		Don't Know		
Other:				
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		Sports Medicine		
Podiatrist		No		
Don't Know				
5. Has there been a recent injury?				
Within the past two months		No		
More than two months		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		8 or more weeks		
4 weeks		None		
6 weeks		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		Splinting/Bracing		
Steroid injections		Other:		
Home exercise or physical therapy (PT)		No Treatment		
Pain medication other than N-S-A-I-D-S		Don't Know		

Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: