MRI and CT - Head and CT Neck 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:

CT NECK:	☐ 70490	☐ 70491	☐ 70492	
MRI HEAD:	☐ 70336	☐ 70540	☐ 70542	☐ 70543
	☐ 70551	☐ 70552	☐ 70553	
CT HEAD:	☐ 70450	☐ 70460	☐ 70470	☐ 70496
	☐ 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. Is this test to image the spine? ◯ Yes ◯ No ◯ Don't Know

4. Is cancer suspected?

- ◯ Suspected, not confirmed
- ◯ Not suspected
- ◯ Known history
- ◯ Don't Know

5. Is there a neck mass? ◯ Yes ◯ No ◯ Don't Know

6. Is the neck mass painful? ◯ Yes ◯ No ◯ Don't Know

7. Has there been difficulty or pain with swallowing? ◯ Yes ◯ No ◯ Don't Know

8. Is a thyroid problem suspected? ◯ Yes ◯ No ◯ Don't Know

9. Has a neck ultrasound been:

- ◯ Done
- ◯ Planned
- ◯ Neither
- ◯ Don't Know

10. Is neck surgery planned? ◯ Yes ◯ No ◯ Don't Know

11. Is there previous head imaging for this problem within the past three years? ◯ Yes ◯ No ◯ Don't Know

12. Date of previous head imaging?

- ◯ None
- ◯ Don't Know

Other:

13. Has there been a recent onset of hemiplegia? ◯ Yes ◯ No ◯ Don't Know

14. Is Dementia or Alzheimer's disease suspected?

- ◯ Dementia
- ◯ Alzheimer's
- ◯ Both
- ◯ Neither
- ◯ Don't Know

15. Has there been a new onset of epileptic seizure? ◯ Yes ◯ No ◯ Don't Know

16. Is there a history of migranes? ◯ Yes ◯ No ◯ Don't Know

Clinical Information

17. Has there been persistent unresponsive vertigo despite several days of treatment?	Yes	No	Don't Know
18. Has a trial of physician-directed treatment been completed?	Yes	No	Don't Know
19. Has physician-directed treatment of at least 3 weeks failed to help the problem?	Yes	No	Don't Know

20. When did treatment start?

- Less than 1 month ago
- More than 1 month ago
- Don't Know
- No Treatment
- Does Not Apply

21. Can the patient walk normally?	Yes	No	Don't Know
22. Is there a known brain tumor?	Yes	No	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: