



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:					

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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	Phone call with office staff		
	Office visit	Phone call with physician		
	Email	Don't Know		
	Other:			
	3. Is this test to image the spine?			Yes No Don't Know
	4. Is cancer suspected?			
	Suspected, not confirmed	Known history		
	Not suspected	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	Neither		
Planned	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	Both	Don't Know		
Alzheimer's	Neither			
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	No Treatment					
	More than 1 month ago	Does Not Apply					
	Don't Know						
	21. Can the patient walk normally?	Yes	No	Don't Know			
22. Is there a known brain tumor?	Yes	No	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:			