MRI and CT Head and MRI Spine 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:								
C-Spine:	☐	72141	☐	72142	☐	72156		
T-Spine:	☐	72146	☐	72147	☐	72157		
L-Spine:	☐	72148	☐	72149	☐	72158		
MRI Head:	☐	70551	☐	70552	☐	70553		
CT Head:	☐	70450	☐	70460	☐	70470	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. Is there a previous imaging for this problem within the past 6 months?

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

5. Is there a personal history of cancer other than ordinary skin cancer? ◯ Yes ◯ No ◯ Don't Know

6. Has there been a failure to improve with physician directed treatment?

- ◯ 4 weeks or less
- ◯ 6 weeks
- ◯ Don't Know
- ◯ 8 or more weeks
- ◯ No Treatment

7. In the last two months, has there been significant trauma to the spine involving:

- ◯ A motor vehicle accident (MVA)
- ◯ Any fall landing on the head
- ◯ A fall from a height
- ◯ A head trauma with loss of consciousness
- ◯ No injury or trauma
- ◯ Other injury:
- ◯ Don't Know

8. Is the imaging request related to back or neck pain? ◯ Yes ◯ No ◯ Don't Know

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

10. Date of previous head imaging?

- ◯ Don't Know

Other:

- ◯ None

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

Clinical Information

12. Is Dementia or Alzheimer's disease suspected?

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

13. Has there been a new onset of epileptic seizure?	◯ Yes	◯ No	◯ Don't Know
14. Is there a history of migraines?	◯ Yes	◯ No	◯ Don't Know
15. Has there been persistent unresponsive vertigo despite several days of treatment?	◯ Yes	◯ No	◯ Don't Know
16. Has a trial of physician-directed treatment been completed?	◯ Yes	◯ No	◯ Don't Know
17. Has physician-directed treatment of at least 3 weeks failed to help the problem?	◯ Yes	◯ No	◯ Don't Know

18. When did treatment start?

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

19. Can the patient walk normally?	◯ Yes	◯ No	◯ Don't Know
20. 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: