



MRI and CT Head 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 Head:	70450	70460	70470	
		MRI Head:	70551	70552	70553	
		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	Other:		
	Office visit	Phone call with physician			
	Email	Don't Know			
	3. Is there previous head imaging for this problem within the past three years?		Yes	No	Don't Know
	4. Date of previous head imaging?		Date:		None
			Other:		Don't Know
	5. Has there been recent onset of Hemiplegia?		Yes	No	Don't Know
	6. Is Dementia or Alzheimer's disease suspected?				
	Dementia	Both	Don't Know		
	Alzheimer's	Neither			
	7. Has there been a new onset of epileptic seizure?		Yes	No	Don't Know
	8. Is there a history of migranes?		Yes	No	Don't Know
9. Has there been persistent unresponsive vertigo despite several days of treatment?		Yes	No	Don't Know	
10. Has a trial of physician-directed treatment been completed?		Yes	No	Don't Know	
11. Has physician-directed treatment of at least 3 weeks failed to help the problem?		Yes	No	Don't Know	
12. When did treatment start?					
Less than 1 month ago	No Treatment	Don't Know			
More than 1 month ago	Does Not Apply				
13. Can the patient walk normally?		Yes	No	Don't Know	
14. 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
Signature:				Date:		