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:

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
- ◯ Phone call with office staff
- ◯ Phone call with physician
- ◯ Don't Know
- Other:

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:

Other:

◯ None
◯ 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
- ◯ Alzheimer's
- ◯ Both
- ◯ Neither
- ◯ Don't Know

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

13. Can the patient walk normally? ◯ Yes ◯ No ◯ Don't Know

14. 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: