Utilization Management
Phone No.: 1-877-284-0102   Fax No.: 1-800-510-2162

HealthLink MRI of the BRAIN

Date: _______________ Notification # ____________________________(provided after initial review)

A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Provider's Name: ____

Address____

Phone No.______________________________ Fax No.______________________________

Patient Information

Patient's Name____

ID Number______________________________Patient's DOB: ______________________

Address____

Height: ________ Weight: _______ Daytime Phone No.______________________________

Ordering Physician Information

Physician's Name____

Address____

Phone No.______________________________ Fax No. (Required)______________________

TIN: ________________________

Treatment Information

Diagnosis & Past Medical History (related to equipment):______________________________

____

____

Recent History of Head Trauma ☐ YES ☐ NO

If yes, explain: ____

____

Cerebrovascular Accident (CVA), Stroke or Transient Ischemic Attack (TIA) ☐ YES ☐ NO

If yes, explain: ____

____

Infection or Inflammatory Conditions ☐ YES ☐ NO

If yes, explain: ____

____

Headache ☐ YES ☐ NO

If yes, explain: ____

____

Malignant (primary or metastatic) and Benign Lesions (known or suspected) ☐ YES ☐ NO
If yes explain: ____
____

Demyelinating and Dysmyelinating Disease ☐ YES ☐ NO
If yes, explain: ____
____

Congenital Anomalies ☐ YES ☐ NO
If yes, explain: ____
____

Vascular abnormalities ☐ YES ☐ NO
If yes, explain: ____
____

Hemorrhage or Hematoma ☐ YES ☐ NO
If yes, explain: ____
____

Central Nervous System (CNS) Signs or Symptoms ☐ YES ☐ NO
If yes, explain diagnosis and symptoms ______________________________
____
____
____

Related to Neurosurgical Procedures? ☐ YES ☐ NO
If yes, explain procedure ______________________________________
____
____
____

Contact Information
Contact Person____
Phone No.______________________ Fax No.______________________

Staff Signature/Title:______________________________ Date:______________

**Preferred provider available for DME and HI services*

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.