



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

MRIs of Cervical, Thoracic and Lumbar Spine Pre-Review
Abdomen, Pelvis and Thoracic Cavity Only

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.

Provider Information

Provider's Name:
Address
Phone No. Fax: (Required)

Patient's Information

Patient's Name:
ID Number Patient's DOB:
Address
Height Weight Daytime Phone No.

Ordering Physician's Information

Ordering Physician's Name:
Address
Phone: Fax:
TIN:

Treatment Information

Procedure:
CPT Code:
Date of Procedure:
Place of Service:
If related to an accident, please indicate date, type and site:

DIAGNOSIS/POSSIBLE INDICATIONS (check all that apply)

- Spine Fracture, Level
Spinal Tumor, Level
Primary or Metastatic Bone Cancer
Suspected Primary or Metastatic Bone
Spinal Osteomyelitis
Demyelinating Disease, (specify)
Other, (specify)
Cauda Equina Syndrome
Meningocele/ Myelomeningocele
Epidural Abscess
GYN Cancer, (specify)
Suspected loosening of prosthesis or cement
Anatomical Abnormality of the Heart
Nephrolithiasis
Ascites
Liver Mass
Adrenal Mass
Pancreatic Mass
Pancreatitis
Pancreatic Pseudocyst
Appendicitis
Abdominal Abscess
Diverticulitis
Thymoma
Lung Mass
Lung Cancer
Emphysema
Atelectasis
Pleural Effusion
Bronchiectasis
Pulmonary Embolus
Mediastinal Mass
Hilar Enlargement
Thoracic Aneurysm
Myasthenia Gravis

SYMPTOMS (check all that apply)

- Cough
Dysphagia
Dyspnea
Fecal Incontinence
Guarding
Pain with ROM
Hemiparesis
Hemoptysis
Mental Status Changes
Nausea/Vomiting
Pain at site, (specify)
Radiating/Duration
Rebound Tenderness
Temperature (> 100.4, duration)
Tingling/Numbness
Weakness
Other, (specify)

PREVIOUS RADIOLOGY EXAMS (check all that apply)

- Plain Films MRI Nuclear Medicine, (specify) _____
 CT Scan Barium Enema Other, (specify) _____
 Ultrasound MRA _____

Findings _____

APPLICABLE LAB TESTS	RESULTS

APPLICABLE MEDICATION(S)	DOSAGE	FREQUENCY	DATE STARTED	DATE STOPPED

Previous Treatment Information

- OT, duration _____ PT, duration _____
 Chiropractic, duration _____
 Surgery, specify type and date _____
 Other, specify type and duration _____

Additional Comments:

Contact Information

Contact Person _____
 Phone No.: _____ Fax No.: _____

Staff Signature/Title: _____ Date: _____

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.