



**Utilization Management**  
**Phone: 1-877-284-0102      Fax: 1-800-510-2162**

**MRIs of Spine - Cervical, Thoracic, Lumbar, Sacral Precertification Review**

Date: \_\_\_\_\_ Reference #: \_\_\_\_\_ (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 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Ordering Physician Information**

Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Treatment Information**

Primary Procedure: \_\_\_\_\_  
 Procedure (ICD-9) Code: \_\_\_\_\_  
 Date of Procedure: \_\_\_\_\_  
 Place of Service: \_\_\_\_\_  
 Related to an Accident:       YES     NO  
 If yes, please indicate date and type of injury: \_\_\_\_\_

**DIAGNOSIS/POSSIBLE INDICATIONS (check all that apply)**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Cauda Equina Syndrome                 | <input type="checkbox"/> Herniated Disc                    | <input type="checkbox"/> Spinal Stenosis      | <input type="checkbox"/> Spinal Tumor                                |
| <input type="checkbox"/> Degenerative Disc Disease             | <input type="checkbox"/> Meningocele/ Myelomeningocele     | <input type="checkbox"/> Spine Fracture       | Level _____  |
| <input type="checkbox"/> Demyelinating Disease (specify) _____ | <input type="checkbox"/> Primary or Metastatic Bone Cancer | Level _____                                   | <input type="checkbox"/> Suspected loosening of Prosthesis or cement |
| <input type="checkbox"/> Epidural Abscess                      | <input type="checkbox"/> Spacticity                        | <input type="checkbox"/> Spinal Osteomyelitis | <input type="checkbox"/> Suspected Primary or Metastatic Bone        |
|  |  | <input type="checkbox"/> Spinal Trauma        |  |

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.

Other (specify) \_\_\_\_\_

**SYMPTOMS (check all that apply)**

- Hemiparesis       Pain at site (specify) \_\_\_\_\_       Radiating       Tingling/Numbness  
 Pain with ROM      \_\_\_\_\_      Duration \_\_\_\_\_       Weakness  
 Other (specify) \_\_\_\_\_

**PREVIOUS RADIOLOGY EXAMS (check all that apply)**

- CT Scan       Nuclear Medicine (specify) \_\_\_\_\_       Ultrasound \_\_\_\_\_  
 MRA  
 MRI      \_\_\_\_\_       Other (specify) \_\_\_\_\_  
 Plain Films

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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Provider Contact Information**

Contact Person: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_