



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

MRI of the Brain Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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 Diagnosis: _____
 Diagnosis (ICD-9) Code: _____
 Primary Procedure: _____
 Procedure (ICD-9) Code: _____
 Reason for MRI: _____
 Pertinent Medical History (submit history, physical and include previous treatments and dates): _____

Is there recent history of head trauma? YES NO
 If yes, explain: (date of onset & symptoms) _____

Has there been a Cerebrovascular Accident (CVA), stroke or Transient Ischemic Attack (TIA)? YES NO
 If yes, explain: (date of onset & symptoms) _____

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.

Has there been an infection or inflammatory conditions? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been a headache? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been malignant (primary or metastatic) and benign lesions (known or suspected)? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been Demyelinating and Dysmyelinating Disease? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been congenital anomalies? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been vascular abnormalities? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been hemorrhage or hematoma? YES NO

If yes, explain: (date of onset & symptoms) _____

Has there been Central Nervous System (CNS) Signs or Symptoms? YES NO

If yes, explain: (date of onset & symptoms) _____

Is MRI related to Neurosurgical Procedures? YES NO

If yes, explain procedure: _____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

**Preferred provider available for DME and Home Infusion services*