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

MRA of Head and/or Neck 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

Ordering Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Treatment Information

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Procedure (ICD-10) Code:_____

Date of Procedure:_____

Place of Service (include name, address and phone): _____

_____

Is request related to an accident? ☐ YES ☐ NO

If yes, please indicate date and type of injury: _____

_____

Does patient have known or suspected diagnosis of the following:

Aneurysm ☐ YES ☐ NO

Arteriovenous Malformation ☐ YES ☐ NO

Is there known or suspected subarachnoid, subdural, intracerebral hemorrhage? ☐ YES ☐ NO

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 trauma? ☐ YES ☐ NO

Has there been cerebral aneurysm? ☐ YES ☐ NO

Is there recent onset of "worst headache of life"? ☐ YES ☐ NO

Is there an alteration in cognitive status? ☐ YES ☐ NO

Is there any neurological defect (e.g. loss of vision)? ☐ YES ☐ NO

Is MRA of Head to determine site of bleeding? ☐ YES ☐ NO

Is MRA of Head for pre- or post-operative surgical planning of the resection of AVMs or aneurysms when the results may alter member management? ☐ YES ☐ NO

Is MRA of Head for pre- or post-procedure planning for percutaneous vascular intervention for aneurysms?

☐ YES ☐ NO

Is MRA of Head for pre- or post-procedure planning for percutaneous vascular intervention for Arteriovenous Malformations? ☐ YES ☐ NO

Is MRA follow-up for?

Known AVM ☐ YES ☐ NO

Known non-ruptured intracranial aneurysm ☐ YES ☐ NO

Recent CVA ☐ YES ☐ NO

Does patient have known diagnosis of suspected Stenosis? ☐ YES ☐ NO

Is MRA of Neck to evaluate for extracranial carotid arteries causing transient ischemic attack (TIA) and cerebral vascular accident? ☐ YES ☐ NO

Has other imaging been completed? ☐ YES ☐ NO

If yes, please describe: _____

_____

Will MRA of Neck alter member management? ☐ YES ☐ NO

Is MRA of Neck to evaluate for vertebrobasilar arteries in individuals with symptoms highly suggestive of vertebrobasilar syndrome? ☐ YES ☐ NO

SYMPTOMS (check all that apply):

☐ binocular vision loss ☐ dysarthria ☐ none

☐ positional vertigo ☐ diplopia

Will MRA alter member management? ☐ YES ☐ NO

Is MRA of Head for other vascular conditions? ☐ YES ☐ NO

OTHER VASCULAR CONDITIONS (check all that apply):

☐ Not Applicable

☐ Congenital anomalies

☐ Dissection

☐ Dural arteriovenous fistula

☐ Intramural hematoma

☐ Traumatic vascular injury

☐ Suspected thrombosis (venous or arterial) of the major vessels

☐ Vascular abnormalities associated with sickle cell disease in children

☐ Vasculitis

☐ Vasculopathy, including fibromuscular dysplasia

☐ Venous thrombosis (including dural venous sinus thrombosis) or compression

☐ Other, please specify _____

_____

☐ Congenital anomalies of the carotid and vertebrobasilar circulations (please specify) _____

_____

_____

Postoperative evaluation of carotid endarterectomy associated with new signs or symptoms? ☐ YES ☐ NO

EVALUATION OF TUMORS

Preoperative evaluation of blood supply to tumors, such as carotid artery (e.g., glomus tumor)? ☐ YES ☐ NO

Known or Suspected Stenosis or Occlusion of either of the following:

Stenosis or occlusion of intracranial carotid and cerebral arteries ☐ YES ☐ NO

Stenosis or occlusion of vertebrobasilar arteries in individuals with symptoms highly suggestive of vertebrobasilar syndrome ☐ YES ☐ NO

Please list symptoms, (e.g. binocular vision loss, [positional] vertigo, dysarthria, diplopia): _____

_____

_____

Will MRA of Head results alter member management? ☐ YES ☐ NO

Is MRA of Head for Evaluation of the following tumors:

Evaluation of cerebral arteriovenous neoplasm, hemangioma ☐ YES ☐ NO

Preoperative planning to define the vascular supply of intracranial or glomus tumors ☐ YES ☐ NO

Evaluation of suspected dural sinus obstruction or invasion ☐ YES ☐ NO

Is MRA of Head for evaluation of the following Signs or Symptoms:

Sudden onset of headaches associated with exertion or positional changes ☐ YES ☐ NO

Pulsatile tinnitus in individuals with signs or symptoms suggestive of a vascular lesion ☐ YES ☐ NO

Is MRA of Head for other vascular conditions?

Congenital anomalies of the carotid and vertebrobasilar circulations (please specify): _____

_____

Additional Comments

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

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