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-10) 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)

☐ Cauda Equina Syndrome
☐ Degenerative Disc Disease
☐ Demyelinating Disease (specify) _____
☐ Epidural Abscess
☐ Herniated Disc
☐ Meningocele/ Myelomeningocele
☐ Primary or Metastatic Bone Cancer
☐ Spacticity
☐ Spinal Stenosis
☐ Spine Fracture
Level _____
☐ Spinal Osteomyelitis
☐ Spinal Trauma
☐ Spinal Tumor
Level _____
☐ Suspected loosening of Prosthesis or cement
☐ Suspected Primary or Metastatic Bone

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: _____