

CT PRIOR AUTHORIZATION FAX REQUEST FORM

Specific for CT of the Spine (Cervical through Lumbar)
 CPT codes 72125 through 72133

FAX TO CARECORE NATIONAL @ 800-540-2406

Please also use this form as a "guide" for phone and web authorizations

**PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED COMPLETELY
 FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST**

Patient Name _____	DOB _____
Insurance Plan _____	Subscriber ID _____
Referring Physician _____	Specialty _____
Physician Address _____	City _____ State _____
Physician Fax # (_____) _____	Phone # (_____) _____
Date of Request _____	Contact Person _____
Imaging Facility Name _____	Site Phone # (_____) _____
Site Address _____	City _____ State _____
Physician Fax # (_____) _____	
Test Requested _____	CPT Code _____

What is the working diagnosis? _____ Rule out diagnosis? _____

Red Flags If no Red Flags present, documentation of previous conservative treatment is required

- | | |
|---|---|
| <input type="checkbox"/> History of malignancy | <input type="checkbox"/> IV Drug use |
| <input type="checkbox"/> Suspicion of malignancy | <input type="checkbox"/> Saddle anesthesia |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Abnormal CBC, Sed Rate |
| <input type="checkbox"/> Urinary Tract infections | <input type="checkbox"/> Major motor weakness of a limb |
| <input type="checkbox"/> Pain increased at rest | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Bladder and bowel dysfunction | |
| <input type="checkbox"/> Immunosuppression | |
| <input type="checkbox"/> Infection (<i>suspected osteomyelitis, preoperative evaluation of osteomyelitis</i>) | |
| <input type="checkbox"/> Neurological Compromise | |
| <input type="checkbox"/> Trauma (<i>please specify type and date</i>) _____ | |

Past Medical History (Check all that apply)

<input type="checkbox"/> History of prior spinal procedure: <i>note type and date</i> _____	Yes	No
<input type="checkbox"/> History of diabetes, dialysis or peripheral vascular disease	Yes	No
<input type="checkbox"/> Possible unstable spinal fracture by x-ray	Yes	No
Is the patient over age 50 or under age 20	Yes	No
<input type="checkbox"/> Other (<i>please specify</i>) _____		

Symptoms/Complaints (Check all that apply)**Duration of symptoms**

- Neck pain _____
- History of infection or penetrating wound _____
- Radiculopathy _____
- Bowel incontinence _____
- Bladder dysfunction _____
- Spasticity _____
- Diminished rectal sphincter tone _____
- Infection _____
- Symptoms interfere with ADL _____
- Severe motor deficit /foot drop _____
- Neurogenic claudication _____
- Other (please specify) _____

Findings on Physical Exam (include provocative test if applicable)

- Sensory deficit
- Clinical suspicion of spinal fracture
- Point tenderness
- ROM
- Muscle strength reflexes
- Straight leg raising
- Loss of muscle strength
- Other (please specify) _____

Previous Treatment History (Check all that apply)

- Use of NSAIDS, opiates/narcotics, other pain management medications without relief of symptoms:

Name of drug: _____	Days/Wks taken _____	Effective: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of drug: _____	Days/Wks taken _____	Effective: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of drug: _____	Days/Wks taken _____	Effective: <input type="checkbox"/> Yes <input type="checkbox"/> No
- Activity Modification: Days/weeks duration _____
Symptoms/pain worsening during the course of activity modification? Yes No
- Physical Therapy: Days/weeks duration _____
Symptoms/pain worsening during the course of PT treatment? Yes No
- Prior diagnostic testing for this problem: *Test* _____
Date testing completed _____
Findings _____
- Other: (please specify) _____

Physician Signature _____

Date _____