Request for Criteria

PLEASE NOTE:
Request for Criteria must be submitted within **1-business day** of the date that the criteria request is received by an eviCore healthcare employee.

Case Information	
Date Request Received by eviCore	
eviCore Employee Requesting Criteria	
Episode No	
CPT Code	
Health Plan	
Who Is Requesting Criteria (check box)	☐Provider ☐Member ☐Other
Provider Information	
☐Yes, I verified the mailing address and fax number are correct in ImageOne. *(If the mailing address and/or fax number is not correct in ImageOne, please provide below.)*	
Method To Be Sent	☐Mail ☐Fax
Physician Requesting Criteria	
Mailing Address in ImageOne Verified	☐Correct ☐Address Update Provided Below
Mailing Address	
City, State, Zip	,
Fax Number	- -
Member Information	
☐ Yes, I verified the mailing address is correct in ImageOne. *(If the mailing address is not correct in ImageOne, please provide below.)*	
Method To Be Sent	☐Mail ☐Fax
Member Name	
Mailing Address in ImageOne Verified	☐Correct ☐Address Update Provided Below
Mailing Address	
City, State, Zip	,
Fax Number (if Fax method requested)	- -
Additional Information (if needed)	
Provide specific information and/or additional detailed instructions.	

ACTION:
Please complete this form and **email** it within 1 business day to reqcriteria@eviCore.com with "Request for Criteria" as the subject of the email.