



Clinical Certification Request for Cardiac CT, MRI, and PET

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

Patient/Member	First Name:		Middle Initial:		Last Name:	
	DOB (mm/dd/yyyy):				Gender: Male Female	
	Street Address:				Apt #:	
	City:			State:		Zip:
	Home Phone:		Cell Phone:		Primary Contact: Home Cell	
	Health Plan:		Member ID:		Group ID:	
Ordering Provider	First Name:			Last Name:		
	Primary Specialty:		TIN:		NPI:	
	Physician Phone:			Physician Fax:		
	Address:				Suite #:	
	City:		State:		Zip:	
	Office Contact:				Ext:	
	Contact Email:					
Facility/Site	First Name:			Last Name:		
	Group/Site Name:					
	Primary Specialty:		TIN:		NPI:	
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:		State:		Zip:	
Procedure	Check all applicable CPT Codes:	75557	75559	75561	75563	Other:
		75565	75571	75572	75573	
		75574	78459	78491	78492	
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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What best describes the reason for ordering this exam? (Select one)

Pre-operative assessment for non-cardiac surgery

Known coronary artery disease (CAD)

New diagnosis of congestive heart failure (CHF)

New diagnosis of cardiomyopathy (CM)

Suspected coronary artery disease and symptoms

Screening for coronary artery disease and asymptomatic

Congenital heart disease

Other (please describe):

If symptomatic, please answer the following:

Is the chest pain substernal?	Yes	No
Is there arm pain?	Yes	No
Is there jaw pain?	Yes	No
Is the pain relieved with nitroglycerin or rest?	Yes	No
Is there shortness of breath?	Yes	No
Does the pain wake the patient from sleep?	Yes	No
Is the pain worse with inspiration?	Yes	No
Does the pain occur at rest?	Yes	No
Is the pain brought on by exercise or emotional upset?	Yes	No

For asymptomatic CAD screening, please answer the following:

Does the patient have diabetes?	Yes	No
Is the patient being treated with medication for hypertension?	Yes	No
Has the patient smoked cigarettes within the last month?	Yes	No
What is the systolic blood pressure?	Yes	No
What is the total cholesterol?	Yes	No
What is the HDL cholesterol?	Yes	No

For CPT 75574, does the patient have any of the following?

Atrial fibrillation	Yes	No
Renal insufficiency	Yes	No
Multifocal Atrial Tachycardia (MAT)	Yes	No
Inability to lie flat	Yes	No
Inability to obtain heart rate < 65 beats per minute	Yes	No
Calcium Score > 1000	Yes	No

Clinical Information	For CPT 75574, does the patient have any of the following? (cont'd)					
	Normal Catheterization < 1 year ago		Yes	No		
	Inability to breath hold > 8 seconds		Yes	No		
	What is the patient's height in inches?		Ht:			
	What is the patient's weight in pounds?		Wt:			
	Additonal Information/Comments:					
Submitter	Who is making this request?					
	Ordering Physician		Facility	Other:		
	Print Name:					
	Title:	MD	RN	LPN	PA	NP
	Signature:		Date:			