



Cardiac - Transthoracic Echo Imaging Request

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: | 93303 | 93307 | 93321 | |
| | | 93304 | 93308 | 93325 | |
| | | 93306 | 93320 | Other: | |
| Diagnosis | Diagnosis, if known or rule out: | | | | |
| | ICD-10 Codes: | | | | |
| | Retro Date of Service: | | | | |

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1. Date of the most recent office visit or other documented contact with physician:

Date (mm/dd/yyyy):

Less than 30 days

More than 30 days

Don't know

2. Type of most recent documented contact with physician?

Hospital

Office visit

Phone call with office staff

Phone call with physician

Email

Other (please describe):

Don't know

3. What are the reasons for requesting this Echo/TTE? Select all that apply.

Murmur

Valve disease

Hearth failure, no change in clinical status (no new symptoms)

Arrhythmias (example: atrial flutter/fibrillation, ventricular tachycardia)

Source of embolus

Known congenital heart disease

Assess results of therapy

Routine follow up study

Systemic hypertension (high blood pressure)

Scout images for stress echo

None of the above

Don't know

4. When was the most recent prior TransThoracic Echo (TTE) performed?

No prior TTE

Less than 6 months ago

Between 6 months and less than 1 year

One year or greater

Don't know

| | | | | |
|----------------------|--|--|--|--|
| Clinical Information | 5. What heart-related conditions are new or have worsened? Select all that apply. | | | |
| | <div>None</div> <div>Chest pain</div> <div>Leg edema (swelling)</div> <div>Pulmonary hypertension</div> <div>Syncope (fainting), dizziness, TIA (transient ischemic attack) or suspected stroke</div> <div>None of the above</div> <div>Don't know</div> | | | |
| | Additional Information/Comments: <div></div> | | | |
| Submitter | Who is making this request? Ordering Physician Facility Other: | | | |
| | Print Name: <div> Title: MD RN LPN PA NP Other: </div> <div> Signature: Date: </div> | | | |