



CT Abdomen and Pelvis - Appendicitis 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 field. 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. **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:	CT ABD:	74150	74160	74170	
		CT PELVIS:	72192	72193	72194	
		CT ABD and PELVIS:	74176	74177	74178	Other:
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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Clinical Information	1. Date of most recent office visit or other contact with physician:			Don't Know			
	2. Type of most recent documented contact with physician?						
	Hospital	Phone call with office staff					
	Office visit	Phone call with physician					
	Email	Don't Know					
	Other:						
	3. Is abdominal or pelvic pain present?	Yes	No	Don't Know			
	4. Is this for right lower quadrant pain?	Yes	No	Don't Know			
	5. Is fever present?	Yes	No	Don't Know			
	6. Is there an elevated white blood cell count?	Yes	No	Don't Know			
7. Is abdominal guarding or rebound tenderness present?	Yes	No	Don't Know				
Additional Information/Comments:							
Submitter	Who is making this request?			Ordering Physician	Facility	Other:	
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:			Date:			