



CT Abdomen and Pelvis - Renal Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, and ECG. If there are any inconsistencies with the medical office records, please elaborate in the comment field. If you do not 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:	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:						

CONFIDENTIALITY NOTICE: This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information is intended only for the use of the recipient (s) named above. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify eviCore healthcare and destroy the original transmission and its attachments without saving them in any manner.

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. Where is the location of the pain?		Above umbilicus (belly button)	Does not have pain
			Below umbilicus (belly button)	Don't Know
	5. Is flank or back pain present?			Yes No Don't Know
6. Is there blood in the urine?			Yes No Don't Know	
7. Is this to evaluate kidney stones or recent history of kidney stones?			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: