



CT Chest/Neck - 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:	CT CHEST:	71250	71260	71270		
		CTA CHEST:	71275				
		CT NECK:	70490	70491	70492	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 this for cancer diagnosis?		Yes	No	Don't Know
4. Is there evidence of cancer in the chest?		Yes	No	Don't Know
5. Is there a new nodule or mass on chest x-ray or imaging study?		Yes	No	Don't Know
6. Was a chest x-ray done within the last 4 weeks and read by a radiologist?		Yes	No	Don't Know
7. Has a chest CT been done within the past year?		Yes	No	Don't Know
8. Is chest pain present?		Yes	No	Don't Know
9. Has a D-dimer been done?		Normal	Abnormal	Test Not Done
				Don't Know
10. Is this test to image the spine (neck bones or spinal cord)?		Yes	No	Don't Know
11. Is cancer suspected?		Suspected, not confirmed		Known History
		Not Suspected		Don't Know
12. Is there a neck mass?		Yes	No	Don't Know
13. Is the neck mass painful?		Yes	No	Don't Know
14. Has there been difficulty or pain with swallowing?		N/A	Yes	No
				Don't Know
15. Is a thyroid problem suspected?		Yes	No	Don't Know
16. Has a neck ultrasound been:		Done	Planned	Neither
				Don't Know
17. Is neck surgery planned?		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:	