



CT Chest 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			
		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 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?	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:			