



CT Upper and Lower Extremity 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 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 UPPER EXT:	73200	73201	73202	
		CT LOWER EXT:	73700	73701	73702	
		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. What was the date for the FIRST office visit for this episode of symptoms (should pain, knee pain, etc.)?			
Date:	This is the first visit for this episode	Don't Know	
4. Has a specialist evaluation been completed?	Yes	No	Don't Know
5. Has there been a recent injury?	Yes	No	Don't Know
6. Has an X-ray been done?	Yes	No	Don't Know
7. Is there a personal history of cancer other than ordinary skin cancer?	Yes	No	Don't Know
8. Is this study to evaluate arthritis?	Yes	No	Don't Know
9. What is the range of motion?	Full Motion	Limited/Painful	Don't Know
10. Has there been a period of conservative treatment?			
3 weeks or less	8 or more weeks		
4 weeks	No Treatment		
6 weeks	Don't Know		
11. Indicate type of physician directed treatment (select all that apply):			
N-S-A-I-D-S (Nonsteroidal anti-inflammatory drugs) and/or oral steroids	Splinting/Bracing		
Steroid injections	Other:		
Home exercise or physical therapy (PT)	No Treatment		
Pain medication other than N-S-A-I-D-S	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:			