CT Chest, Abdomen and Pelvis 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 ABD:	☐ 74150	☐ 74160	☐ 74170
CT PELVIS:	☐ 72192	☐ 72193	☐ 72194
CT ABD and PELVIS:	☐ 74176	☐ 74177	☐ 74178
CT CHEST:	☐ 71250	☐ 71260	☐ 71270
CTA CHEST:	☐ 71275		☐ Other:

Diagnosis

Diagnosis, if known or rule out:

ICD-10 Codes:

Date of last visit:

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
- ◯ Office visit
- ◯ Email
- ◯ Other
- ◯ Phone call with office staff
- ◯ Phone call with physician
- ◯ Don't Know

3. Is abodminal or pelvic pain present?	◯ Yes	◯ No	◯ Don't Know

4. Where is the location of pain? Above the Umbilicus or below?

- ◯ Above
- ◯ Below
- ◯ Both
- ◯ Does not have pain
- ◯ Don't Know

5. Is there left lower quadrant pain?	◯ Yes	◯ No	◯ Don't Know
6. Has there been abdominal or pelvis surgery within the past year?	◯ Yes	◯ No	◯ Don't Know
7. Is fever present?	◯ Yes	◯ No	◯ Don't Know
8. Is there an elevated white blood cell count?	◯ Yes	◯ No	◯ Don't Know
9. Is this to evaluate a hernia?	◯ Yes	◯ No	◯ Don't Know
10. Are there unclear findings of previous imaging studies (CT, MRI, Ultrasound, X-ray?)	◯ Yes	◯ No	◯ Don't Know
11. Has there been unexplained or unintentional weight loss?	◯ Yes	◯ No	◯ Don't Know
12. Is there a history of diverticulitis?	◯ Yes	◯ No	◯ Don't Know
13. Has treatment with antibiotics been done in the past week?	◯ Yes	◯ No	◯ Don't Know
14. Is this for cancer diagnosis?	◯ Yes	◯ No	◯ Don't Know
15. Is there evidence of cancer in the chest?	◯ Yes	◯ No	◯ Don't Know
16. Is there a new nodule or mass on chest x-ray or imaging study?	◯ Yes	◯ No	◯ Don't Know
17. Was a chest x-ray done within the last 4 weeks and read by a radiologist?	◯ Yes	◯ No	◯ Don't Know
18. Has a chest CT been done within the past year?	◯ Yes	◯ No	◯ Don't Know
19. Is chest pain present?	◯ Yes	◯ No	◯ Don't Know

Clinical Information

20. Has a D-dimer been done? ◯ Normal ◯ Abnormal ◯ Test not done ◯ 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: