



## 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](http://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:         |                  |              |

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|   |  |                              |                   |                   |
|---|--|------------------------------|-------------------|-------------------|
| <b>Diagnosis</b>  | Diagnosis, if known or rule out:   |                              |                   |                   |
|   | ICD-10 Codes:  |                              |                   |                   |
|   | Date of last visit:  |                              |                   |                   |
| <b>Clinical Information</b>   | 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 pain? Above the Umbilicus or below?                          |                              |                   |                   |
|   | Above  | Does not have pain           |                   |                   |
|   | Below  | Don't Know                   |                   |                   |
|   | Both   |                              |                   |                   |
|   | 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 |                   |

|                                  |                              |                    |               |
|----------------------------------|------------------------------|--------------------|---------------|
| <b>Clinical Information</b>      | 20. Has a D-dimer been done? | Normal             | Test not done |
|                                  |                              | Abnormal           | Don't Know    |
| Additional Information/Comments: |                              |                    |               |
|                                  |                              |                    |               |
| <b>Submitter</b>                 | Who is making this request?  | Ordering Physician | Facility      |
|                                  | Print Name:                  | Other:             |               |
|                                  | Title:                       | MD                 | RN            |
|                                  |                              | LPN                | PA            |
|                                  | NP                           | Other:             |               |
|                                  | Signature:                   | Date:              |               |