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HUSKY HEALTH CONNECTICUT

CT Abdomen and Pelvis - Renal Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. to 888.693.3210. 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. Requests may also be submitted via the web at eviCore.com. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE TO 800.440.5071.**

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:	

Ordering Provider

First Name:	Last Name:	Medicaid ID
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:	Medicaid ID:	
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	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 abdominal or pelvic pain present?	Yes	No	Don't Know
4. Where is the location of the pain?	Above umbilicus (belly button)	Does not have pain	
	Below umbilicus (belly button)	Don't Know	
5. Is flank or back pain present?	Yes	No	Don't Know
6. Is there blood in the urine?	Yes	No	Don't Know
7. Is this to evaluate kidney stones or recent history of kidney stones?	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:

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