

CT Abdomen and Pelvis - General 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:							

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 abdominal or pelvic pain present?	Yes	No	Don't Know
	4. Where is the location of pain?	Does not have pain		Don't Know
	Above umbilicus (belly button)	Below umbilicus (belly button)	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 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?	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	
Additional Information/Comments:				

Submitter	Who is making this request? Ordering Physician Facility Other:						
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:			Date:			