

## CT Chest, Abdomen and Pelvis 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](http://eviCore.com). **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE 'HC', \$\$'(\$)'\$+%**

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	
	CT CHEST:		71250	71260	71270	
	CTA CHEST:		71275	Other:		

**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.

<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
			Other:
	Print Name:		
	Title:	MD	RN
	PA	NP	Other:
	Signature:	Date:	