



Cardiac Rhythm Implantable Device - Pacemaker Implantation

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:	33206	33207	33208	33212	33213
		33214	33221	33224	33225	33227
		33228	33229	33230	33231	33240
		33249	33262	33263	33264	Other:
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:			Retro date of service:		

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Please note: if this procedure is approved and is being performed in an inpatient setting, contact the patient's health plan directly to have the inpatient admission approved after the authorization is issued.

For Symptomatic individuals:

- | | | | |
|--|-----|----|------------|
| 1. Does the individual have symptomatic bradycardia (slow heart rate)?
Symptoms may include syncope, shortness of breath. | Yes | No | Don't Know |
| 2. Does the individual have exertional limitations because their heart rate is unable to achieve an approximate predicted heart rate of 80% (220-age), aka "chronotropic incompetence"? | Yes | No | Don't Know |
| 3. Does the individual have recurrent syncope caused by spontaneously occurring carotid sinus stimulation and carotid sinus pressure that induces ventricular asystole of more than 3 seconds? | Yes | No | Don't Know |

For asymptomatic individuals:

- | | | | |
|--|-----|----|------------|
| 4. Does the individual have symptomatic bradycardia when given medications required for other medical conditions? | Yes | No | Don't Know |
| 5. Does the individual have permanent or intermittent third-degree AV block? | Yes | No | Don't Know |
| 6. Does the individual have advanced second-degree (Mobitz II) AV block or alternating bundle branch block? | Yes | No | Don't Know |
| 7. Does the individual have second-degree AV block and documented periods of asystole greater than or equal to 3.0 seconds? | Yes | No | Don't Know |
| 8. Does the individual have atrial fibrillation and a pause of 5 seconds or longer? | Yes | No | Don't Know |
| 9. Will the individual have catheter ablation of the AV junction intended for a rate control strategy for management of atrial fibrillation? | Yes | No | Don't Know |
| 10. Does the individual have a progressive neuromuscular disease (such as myotonic muscular dystrophy, Kearns-Sayre syndrome, Erb dystrophy (limb-girdle muscular dystrophy), and peroneal muscular atrophy) and any degree of AV block or fascicular block? | Yes | No | Don't Know |
| 11. Does the individual have persistent second-degree AV block in the His-Purkinje system with alternating bundle-branch block or third-degree AV block within or below the His-Purkinje system after myocardial infarction? | Yes | No | Don't Know |
| 12. Is this for a replacement device? | Yes | No | Don't Know |

Additional information/comments:

Clinical Information

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature: _____ Date: _____