

Abdominal Vascular Ultrasound 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 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:	93975		93976		93978		93979	
		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. Has there been prior Ultrasound, CT or MRA for this condition? Select all that apply.		
No prior Ultrasound, CTA or MRA for this condition	Prior MRA	
Prior Ultrasound	Don't Know	
Prior CTA		
4. When was the last Ultrasound, CTA or MRA performed for this condition?		
No prior Ultrasound, CTA or MRA for this condition	More than 6 months ago	
Less than 6 months ago	Does Not Apply	
5. What is the main reason for this request?		
Known or suspected high blood pressure (hypertension)		
Known or suspected liver disease		
Screening study for Abnormal Aortic Aneurysm (AAA)		
Known Abdominal Aortic Aneurysm		
Suspected Abdominal Aortic Aneurysm		
Known or suspected Iliac Artery Aneurysm		
Known or suspected Renal Artery Stenosis (blockage)		
Other known or suspected vascular abnormality		
Other:		
Don't Know		
6. Are there any new symptoms (for example: pain or other symptoms)?		
No symptoms are present	Yes, there are new symptoms	
No new symptoms	Don't Know	
7. Are there new findings on physical exam (such as change in pulses)?		
No physical exam has been done	Yes, there are new findings on the physical exam	
No new findings on physical exam	Don't Know	

Additional Information/Comments:

Large empty rectangular area for providing additional information or comments.

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: