



## Bone Density 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](http://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.**

<b>Patient/Member</b>	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:	
<b>Ordering Provider</b>	First Name:			Last Name:		
	Primary Specialty:		TIN:	NPI:		
	Physician Phone:			Physician Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
	Office Contact:					Ext:
	Contact Email:					
<b>Facility/Site</b>	First Name:			Last Name:		
	Group/Site Name:					
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
<b>Procedure</b>	Check all applicable CPT codes:	76977				
		Other:				
<b>Diagnosis</b>	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. What is the main reason(s) for requesting this ultrasound? Select all that apply.	
Prior MRA	Other:
No prior Ultrasound, CTA or MRA for this condition	Don't Know
4. Has any prior imaging been performed for this condition?	
No prior imaging	Other:
Prior DEXA scan	Don't Know
Prior CT bone density scan (Q-CT)	
5. When was the most recent prior imaging study done for this condition?	
No prior imaging	6 months to less than 12 months ago
Less than 1 week ago	Greater than 1 year ago
1 week to less than 4 weeks ago	Don't Know
1 month to less than 6 months ago	
Additional Information/Comments:	

**Submitter**

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