



## Chest/Mediastinum 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](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:	76604			
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 for this request?		
Suspected fluid in the chest (pleural effusion)		Known or suspected breast abnormality
Follow-up of known fluid within the chest (pleural effusion)		Known or suspected blood vessel abnormality (aorta, vena cava, etc.)
Suspected mediastinal mass		Other:
Known mediastinal mass		Don't Know
Suspected chest or chest wall mass		
4. Has previous simaging been performed for this condition?		
No prior imaging		Prior MRI
Prior ultrasound		Prior CT
Prior chest x-ray		Don't Know
Other:		
5. How many prior imaging studies not including chest x-ray have been performed for this condition?		
None		Four
One		More than Four
Two		Don't Know
Three		
6. When was the most recent prior imaging study done for this condition?		
No prior imaging		6 months to 12 months ago
Less than 1 week ago		More than 1 year ago
1 week to less than 4 weeks ago		Don't Know
1 month to less than 6 months ago		

**Clinical Information**

Additional Information/Comments:

**Submitter**

Who is making this request?      Ordering Physician      Facility      Other:

Print Name:

Title:    MD    RN    LPN    PA    NP    Other:

Signature:

Date: