# Chest/Mediastrinum 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: | ☐ 76604 |
| | ☐ Other: |

## Diagnosis

| |
|---|
| Diagnosis, if known or rule out: |
| ICD-10 Codes: |
| Date of last visit: |

## 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
- ◯ Office visit
- ◯ Email
- ◯ Other:
- ◯ Phone call with office staff
- ◯ Phone call with physician
- ◯ Don't Know

3. What is the main reason for this request?

- ◯ Suspected fluid in the chest (pleural effusion)
- ◯ Follow-up of known fluid within the chest (pleural effusion)
- ◯ Suspected mediastinal mass
- ◯ Known mediastinal mass
- ◯ Suspected chest or chest wall mass
- ◯ Known or suspected breast abnormality
- ◯ Known or suspected blood vessel abnormality (aorta, vena cava, etc.)
- ◯ Other:
- ◯ Don't Know

4. Has previous simaging been performed for this condition?

- ◯ No prior imaging
- ◯ Prior ultrasound
- ◯ Prior chest x-ray
- ◯ Other:
- ◯ Prior MRI
- ◯ Prior CT
- ◯ Don't Know

5. How many prior imaging studies not including chest x-ray have been performed for this condition?

- ◯ None
- ◯ One
- ◯ Two
- ◯ Three
- ◯ Four
- ◯ More than Four
- ◯ Don't Know

6. When was the most recent prior imaging study done for this condition?

- ◯ No prior imaging
- ◯ Less than 1 week ago
- ◯ 1 week to less than 4 weeks ago
- ◯ 1 month to less than 6 months ago
- ◯ 6 months to 12 months ago
- ◯ More than 1 year ago
- ◯ Don't Know

## Clinical Information

Additonal Information/Comments:

## Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: