

## Duplex Scan of Penile Vessels 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:	93980				
		93981				
		Other:				
<b>Diagnosis</b>	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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<b>Clinical Information</b>	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?						
	Peyronie's Disease	Don't Know					
	Evaluation of Erectile Dysfunction (ED)	Other:					
	4. Has previous imaging been performed for this condition? Select all that apply.						
No prior imaging	Prior MRA						
Prior duplex	Don't Know						
Prior CTA	Other:						
5. 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							
Additonal Information/Comments:							
<b>Submitter</b>	Who is making this request?	Ordering Physician	Facility	Other:			
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:				Date:		