



# Extracranial Artery 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:	93875				
		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. Is this study being requested for pneumoplethysmography?		Yes	No	Don't Know		
Additional 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:			