Extremity Venous 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:	☐ 93965	☐ 93970
	☐ 93971	
	☐ 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. Is there a known or suspected Deep Venous Thrombosis (DVT)?

- ◯ Suspected DVT
- ◯ Known DVT
- ◯ None of the above
- ◯ Don't Know

4. Is this ultrasound requested in order to stop treatment for a prior episode of Deep Venous Thrombosis? ◯ Yes ◯ No ◯ Don't Know

5. Are any of the following signs or symptoms present?

- ◯ No signs or symptoms are present
- ◯ Painful arm and leg swelling
- ◯ Arm or leg swelling without pain
- ◯ Arm or leg swelling without swelling
- ◯ Don't Know
- ◯ Shortness of breath
- ◯ Horman's sign
- ◯ Phlebitis
- ◯ Other:

6. Has there been prior imaging for this condition? Choose all that apply.

- ◯ No prior imaging
- ◯ Prior CT
- ◯ Prior Ultrasound
- ◯ Prior MRI
- ◯ Prior MRV (MR Venography)
- ◯ Prior CV (CT Venography)
- ◯ Don't Know

7. Was the prior imaging positive for Deep Venous Thrombosis (DVT)? ◯ Yes ◯ No ◯ Don't Know ◯ No prior imaging study

8. When was the most recent prior imaging study completed?

- ◯ No prior imaging study
- ◯ Less than 5 days ago
- ◯ Greater than 5 days ago
- ◯ Don't Know

9. Are there known or suspected problems with the valves in the veins (venous insufficiency, varicose veins, etc?) ◯ Yes ◯ No ◯ Don't Know

10. Have any of the symptoms and/or findings become worse or changed location since the prior imaging procedure? ◯ Yes ◯ No ◯ Don't Know

Additonal Information/Comments:

Submitter

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

Print Name:

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

Signature: Date: