



## 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](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.**

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:					

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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. Is there a known or suspected Deep Venous Thrombosis (DVT)?				
Suspected DVT	None of the above			
Known DVT	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	Shortness of breath			
Painful arm and leg swelling	Horman's sign			
Arm or leg swelling without pain	Phlebitis			
Arm or leg swelling without swelling	Other:			
Don't Know				
6. Has there been prior imaging for this condition? Choose all that apply.				
No prior imaging	Prior MRV (MR Venography)			
Prior CT	Prior CV (CT Venography)			
Prior Ultrasound	Don't Know			
Prior MRI				
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	Greater than 5 days ago			
Less 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

Additional Information/Comments:

**Submitter**

Who is making this request?      Ordering Physician      Facility      Other:

Print Name:

Title:    MD    RN    LPN    PA    NP    Other:

Signature:

Date: