



Infant Hips 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:	76885				
		76886				
		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. What is the age of the child?				
	Less than 2 weeks old	Older than 6 months			
	2 weeks to less than 4 weeks old	Don't Know			
	1 month to 6 months old				
4. Has there been prior imaging for this condition? Select all that apply.					
No prior imaging	Prior CT				
Prior MRI	Don't Know				
Prior Ultrasound					
5. On physical exam, is there an abnormal hip exam?			Yes	No	Don't Know
			No physical exam has been done		
6. Is there a history of any of the following?					
Family history of hip deformity	Breech delivery				
Foot deformities	Torticollis (wryneck)				
Additional Information/Comments:					

Submitter	Who is making this request? Ordering Physician Facility Other:						
	Print Name:						
	Title:	MD	RN	LPN	PA	NP	Other:
	Signature:			Date:			