



Kidney Transplant 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 main reason(s) for requesting this ultrasound? Select all that apply.

- | | |
|---|---|
| Worsening kidney function | Routine follow-up ultrasound after transplant |
| Pain or tenderness in area of transplant kidney | Don't Know |
| Mass in area of transplant kidney | |

4. Has there been imaging of the transplant kidney? Select all that apply.

- | | |
|---------------------------------|-----------------------------------|
| No prior imaging | 1 month to less than 6 months ago |
| Less than 1 week ago | 6 months to 12 months ago |
| 1 week to less than 4 weeks ago | Greater than 1 year ago |

Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: