



Male Pelvic 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:	76856		76857		
		76870		76872		
		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 for this study?		
Pain	Difficulty with urination	
Suspected mass	Suspected prostatic	
Known mass	Known prostatic	
Hematuria (blood in urine)	Don't Know	
Suspected Benign Prostatic Hypertrophy or Hyperplasia (BPH)	Known Benign Prostatic Hypertrophy or Hyperplasia (BPH)	
Other:		
4. Has there been a prior ultrasound, CT or MRI for this condition? Select all that apply.		
No prior imaging	Prior MRI	
Prior Ultrasound	Other:	
Prior CT	Don't Know	
5. When was the most recent prior imaging for this condition?		
No prior imaging	6 months to less than 1 year ago	
Less than 2 weeks ago	Greater than 1 year ago	
2 weeks to less than 4 weeks ago	Don't Know	
4 weeks to less than 6 months ago		
6. Where is the location of pain?		
There is no pain	Groin or inguinal area	
Scrotum	Other:	
Lower abdominal area	Don't Know	
7. Where is the location of the mass or suspected mass?		
There is no mass or suspected mass	Prostate Gland	
Colon, rectum or other area of intestines	Groin or inguinal area	
Bladder	Penis	
Scrotum/Testicle	Other:	
Don't Know		

Clinical Information

8. Is there a personal history of any of the following? Choose all that apply.

- | | |
|------------------------------------|--|
| Inguinal or abdominal wall area | Testicular Cancer |
| Epididymitis | Benign Prostatic Hyertrophy or Hyperplasia (BPH) |
| Prostate Cancer treated by surgery | Epididymal Cyst/Spermatocoele |
| Prostatis | Prostate Cancer not treated by surgery |
| Varicocele | Bladder Cancer |
| Don't Know | |

9. Are any of the following present? Choose all that apply.

- | | |
|---|--|
| No symptoms or signs present | Mass felt on the scrotum/testicle |
| No abnormal labs are present | Mass/hernia in groin, inguinal area, or abdominal wall |
| Elevated white blood cell count (WBC) | Abnormal urine lab results (urinalysis) |
| Tenderness with palpation of prostate gland | Elevated PSA (Prostate Specific Antigen) |
| Tenderness with palpation of scrotum/testicle | Don't Know |
| Mass felt on digital rectal exam | Other: |

10. Have symptoms, physical exam findings, or abnormal lab tests developed or increased in severity since the prior imaging study? Yes No Don't Know
No prior imaging study

11. What type of treatment has been done for the current condition? Choose all that apply.

- | | |
|--|-------------------|
| No treatment done | Radiation therapy |
| Antibiotics for less than 2 weeks | Surgery |
| Antibiotics for 2 weeks to less than 4 weeks | Pain medication |
| Antibiotics for greater than 4 weeks | Hormone therapy |
| Chemotherapy | Other: |
| Don't Know | |

12. Has there been improvement with treatment? Yes No Don't Know
No treatment has been done

Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: