



Ophthalmic 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:	76510	76511	76512		
		76513	76514	76516		
		76519	76529	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 the requested ultrasound study?	
Measure length of eye prior to cataract surgery	Evaluate known or suspected foreign body
Measure length of eye (no surgery planned)	Evaluate known or suspected disorders of the retina
Evaluate known or suspected hemorrhage	Don't Know
Evaluate known or suspected tumor	Other:
4. Has previous imaging been performed for this condition? Select all that apply.	
No prior imaging	Prior MRI
Prior Ultrasound	Don't Know
Prior CT	Other:
5. When was the most recent prior imaging study done for this condition?	
No prior imaging	1 month to less than 6 months ago
Less than 1 week ago	Greater than 1 year ago
1 week to less than 4 weeks ago	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: