



Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) 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:	G0389				
		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 this a Medicare Advantage health plan? Yes No Don't Know

4. Is there a personal history of cigarette smoking? Yes No Don't Know

5. Is there a family history of Abdominal Aortic Aneurysm (AAA)? Yes No Don't Know

6. Has there been a prior screening ultrasound for Abdominal Aortic Aneurysm (AAA)? Yes No Don't Know

Additonal Information/Comments:

Empty text area for additional information or comments.

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: