



## Sonohysterography 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](http://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.**

<b>Patient/Member</b>	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:	
	<b>Ordering Provider</b>	First Name:			Last Name:	
Primary Specialty:		TIN:	NPI:			
Physician Phone:			Physician Fax:			
Address:				Suite #:		
City:			State:	Zip:		
Office Contact:					Ext:	
Contact Email:						
<b>Facility/Site</b>		First Name:			Last Name:	
	Group/Site Name:					
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
<b>Procedure</b>	Check all applicable CPT Codes:	76831				
		Other:				
<b>Diagnosis</b>	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. Has there been prior imaging (sonohysterography, pelvic ultrasound, CT, MRI, etc.) for this condition?

- |                         |            |
|-------------------------|------------|
| No prior imaging        | Prior CT   |
| Prior pelvic ultrasound | Don't Know |
| Prior MRI               | Other:     |
| Prior sonohysterography |            |

4. 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            | 6 months to 12 months ago         |
| 1 week to less than 4 weeks ago | Greater than 1 year ago           |

Additonal Information/Comments:

**Submitter**

Who is making this request?      Ordering Physician      Facility      Other:

Print Name:

Title:      MD      RN      LPN      PA      NP      Other:

Signature:

Date: