



Transcranial Doppler 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:	93886		93888	93890	
		93892		93893		
		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. Has there been prior imaging (transcranial Doppler, CTA, MRA) for this condition? Select all that apply.

- | | |
|--------------------|------------|
| No prior imaging | Prior MRA |
| Prior transcranial | Don't Know |
| Prior CTA | Other: |

4. When was the most recent imaging study performed?

- | | |
|------------------------------------|---------------------------|
| No prior imaging | 6 months to 12 months ago |
| Less than 1 week ago | Greater than 1 year ago |
| 1 week to less than 4 weeks ago | Don't Know |
| 3 months to less than 6 months 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: