



Unlisted CPT Code 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:	76999				
		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(s) for requesting this ultrasound?		
4. Has there been prior imaging for this condition? Select all that apply.		
No prior imaging	Prior MRI	
Prior CT	Prior X-ray	
Prior MRA	Prior CTA	
Prior Ultrasound	Other:	
Don't Know		
5. When was the most recent imaging study performed?		
No prior imaging	1 month to less than 6 months ago	
Less than 1 week ago	6 months to less than 12 months ago	
1 week to less than 4 weeks ago	Greater than 1 year ago	
Don't Know		
6. Have signs, symptoms, and/or physical exam findings developed or worsened since the most recent prior imaging study?		
No prior imaging study	Yes, new signs or symptoms have developed	
No	Yes, new physical exam findings have developed	
Yes, signs or symptoms have worsened	Don't Know	
Yes, physical exam findings have worsened		
Additional Information/Comments:		

Submitter

Who is making this request?	Ordering Physician	Facility	Other:
Print Name:			
Title:	MD	RN	LPN PA NP Other:
Signature:			Date: