

## **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 ( <i>mm/dd/yyyy</i> ):			Gender:	Male Female					
	Street Address:				Apt #:					
	City:			State:	Zip:					
	Home Phone:		Cell Phone:		Primary Cont	tact:	Home	Cell		
	Health Plan:		Member ID:		Group ID:					
Ordering Provider	First Name:			Last Name:	Name:					
	Primary Specialty:		TIN:		NPI:					
	Physician Phone: Physician Fax					:				
	Address:				Suite #:					
	City:			State:	Zip:					
	Office Contact:					Ext:				
	Contact Email:									
	Contact Email:									
	Contact Email: First Name:			Last Name:						
ite		ne:		Last Name:						
ty/Site	First Name:		TIN:	Last Name:	NPI:					
cility/Site	First Name: Group/Site Nam		TIN:	Last Name: Site Fax:	NPI:					
Facility/Site	First Name: Group/Site Nam Primary Special		TIN:		NPI: Suite #:					
Facility/Site	First Name: Group/Site Nam Primary Special Site Phone:		TIN:							
	First Name: Group/Site Nam Primary Special Site Phone: Address: City:		TIN: 76511	Site Fax:	Suite #:					
	First Name: Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable	lty:		Site Fax: State:	Suite #:					
Procedure Facility/Site	First Name: Group/Site Nam Primary Special Site Phone: Address: City: Check all	lty: 76510	76511	Site Fax: State: 76512	Suite #:					
Procedure	First Name: Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable CPT Codes:	lty: 76510 76513	76511 76514	Site Fax: State: 76512 76516	Suite #:					
	First Name: Group/Site Nam Primary Special Site Phone: Address: City: Check all applicable CPT Codes:	Ity: 76510 76513 76519 nown or rule out:	76511 76514	Site Fax: State: 76512 76516	Suite #:					

**CONFIDENTIALITY NOTICE:** This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information is intended only for the use of the recipient (s) named above. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please immediately notify eviCore healthcare and destroy the original transmission and its attachments without saving them in any manner.

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 retin    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 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		1. Date of most recent office visit or other contact with phys	ician: Don't Know					
Office visit  Phone call with physician    Email  Don't Know    Other:		2. Type of most recent documented contact 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 retine    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 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		Hospital	Phone call with office staff					
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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		Measure length of eye prior to cataract surgery	Evaluate known or suspected foreign body					
Evaluate known or suspected tumor  Other:    4. Has previous imaging been performed for this condition? Select all that apply.  No prior imaging    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		Measure length of eye (no surgery planned)	Evaluate known or suspected disorders of the retina					
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Less than 1 week ago Greater than 1 year ago		Evaluate known or suspected tumor	Other:					
Less than 1 week ago Greater than 1 year ago		4. Has previous imaging been performed for this condition? Select all that apply.						
Less than 1 week ago Greater than 1 year ago		No prior imaging	Prior MRI					
Less than 1 week ago Greater than 1 year ago		Prior Ultrasound	Don't Know					
Less than 1 week ago Greater than 1 year ago		Prior CT	Other:					
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		No prior imaging	1 month to less than 6 months ago					
1 week to less than 4 weeks ago Don't Know		Less than 1 week ago	Greater than 1 year ago					
		1 week to less than 4 weeks ago	Don't Know					
Additonal Information/Comments:		Additonal Information/Comments:						
Who is making this request? Ordering Physician Facility Other:		Facility Other:						
	ter							
Title: MD RN LPN PA NP Other:	l ji							
Print Name: Title: MD RN LPN PA NP Other:	9ng							
Signature: Date:	~	Signature:	Date:					