

NON-OB ULTRASOUND AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS					
Patient Name (First, Last):				DOB:	
Health Plan:		Member ID #:		Group #:	
SECTION 2. ORDERING PROVIDER INFORMATION					
Physician Name (First, Last):					
Primary Specialty:		NPI:		Tax ID:	
Phone #:		Fax #:		Contact Name:	
SECTION 3. FACILITY INFORMATION					
Facility Name:			Facility Tax ID:		NPI:
Address:		City:		State:	Zip:
Phone #:		Fax #:			Date of Service:
SECTION 4. EXAM REQUEST					
CPT Code(s):					
Description:					
ICD Diagnosis Code(s):					
Description:					
Date of first office visit for this condition with any provider:					
Date of most recent office visit for this condition with any provider:					
Type of most recent documented contact with physician:					
<input type="checkbox"/> Consultation	<input type="checkbox"/> Office Visit	<input type="checkbox"/> Email		<input type="checkbox"/> Phone call with physician	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Prior surgery	<input type="checkbox"/> Prior Bone Density		<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____					
What is the main reason(s) for requesting this ultrasound?					
Has there been prior imaging for this condition? Select all that apply.					
<input type="checkbox"/> No prior imaging	<input type="checkbox"/> Prior Ultrasound	<input type="checkbox"/> Prior CTA		<input type="checkbox"/> Prior CT	
<input type="checkbox"/> Prior MRI	<input type="checkbox"/> Prior MRA	<input type="checkbox"/> Prior X-ray		<input type="checkbox"/> Don't know	
<input type="checkbox"/> Other _____					
When was the most recent imaging study performed?					
<input type="checkbox"/> No prior imaging	<input type="checkbox"/> 1 month to less than 6 months ago	<input type="checkbox"/> Don't know		<input type="checkbox"/> Less than 1 week ago	
<input type="checkbox"/> 6 months to less than 12 months ago	<input type="checkbox"/> 1 week to less than 4 weeks ago	<input type="checkbox"/> Greater than 1 year ago			
Have signs, symptoms, and/or physical exam findings developed or worsened since the most recent prior imaging study?					
<input type="checkbox"/> No Prior Imaging	<input type="checkbox"/> Yes, physical exam findings have worsened			<input type="checkbox"/> Don't Know	
<input type="checkbox"/> No	<input type="checkbox"/> Yes, new signs or symptoms have developed				
<input type="checkbox"/> Yes, signs or symptoms have worsened	<input type="checkbox"/> Yes, new physical exam findings have developed				
Additional Information/Comments:					
Who is making this request? <input type="checkbox"/> Ordering Physician <input type="checkbox"/> Facility <input type="checkbox"/> Other					
Print Name: _____				Title: <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> Other	
Signature: _____			Date: _____		

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.