



CARDIAC IMAGING PRIOR AUTHORIZATION FORM

Myocardial Perfusion Imaging (MPI); Stress Echocardiogram; Multiple Gated Acquisition Scan (MUGA);
Transthoracic Echocardiogram (TTE); Transesophageal Echocardiogram (TEE)

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			
<input type="checkbox"/> MPI	<input type="checkbox"/> Stress Echo	<input type="checkbox"/> MUGA	<input type="checkbox"/> TTE
<input type="checkbox"/> TEE	<input type="checkbox"/> Fetal Echo		
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:			
SECTION 5. SELECT APPLICABLE STUDY AND CHECK REASON(S) FOR EVALUATION (CHECK ALL THAT APPLY)			
<input type="checkbox"/> MPI	<input type="checkbox"/> STRESS ECHO	<input type="checkbox"/> MUGA	<input type="checkbox"/> Cardiac MRI
<input type="checkbox"/> Coronary CTA			
<input type="checkbox"/> Preoperative Evaluation	<input type="checkbox"/> Post Operative Evaluation		<input type="checkbox"/> Evaluation during or Prior to Chemotherapy
<input type="checkbox"/> Patient has physical limitation to exercise			
Chest Pain or suspected Angina with: (Check all that apply)	Associated Conditions: (Check all that apply)	Other Indications: (Check all that apply)	
<input type="checkbox"/> Without other symptoms	<input type="checkbox"/> Abnormal EKG	<input type="checkbox"/> Abnormal Test Results (Please provide detail in previous test grid below)	
<input type="checkbox"/> Exacerbated by exercise or relieved by rest	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Anomalous coronary artery	
<input type="checkbox"/> Relieved with Nitroglycerin	<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Congenital heart disease (known/suspected)	
<input type="checkbox"/> Dyspnea (Shortness of Breath)	<input type="checkbox"/> Known CAD	<input type="checkbox"/> Evaluation for myocardial viability	
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> New Onset Heart Failure	<input type="checkbox"/> Pediatric Acquired Heart Disease	
<input type="checkbox"/> Left Arm Pain/Radiating Pain	<input type="checkbox"/> Patient has one or more of the following: heart transplant, aortic aneurysm, and/or carotid narrowing/stenosis	<input type="checkbox"/> Suspected Constrictive Pericarditis	
<input type="checkbox"/> Retrosternal Location		<input type="checkbox"/> Quantification intracardiac shunt	
		<input type="checkbox"/> Quantification valvular regurgitation	
Risk Factors for Coronary Artery Disease: (Check all that apply)			
<input type="checkbox"/> Age greater than 40			
<input type="checkbox"/> CAD/MI in a father, brother, son <50 years old			
<input type="checkbox"/> CAD/MI in a mother, sister, daughter <60 years old			
<input type="checkbox"/> Current Smoker			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Elevated Cholesterol			
<input type="checkbox"/> Hypertension			
<input type="checkbox"/> Other (describe): _____			

Previous Tests	Date	Results
<input type="checkbox"/> Exercise Stress Test		
<input type="checkbox"/> Myocardial Perfusion Imaging (MPI) <input type="checkbox"/> PET <input type="checkbox"/> SPECT		
<input type="checkbox"/> Stress Echocardiogram		
<input type="checkbox"/> Cardiac MRI		
<input type="checkbox"/> Cardiac Catheterization		
<input type="checkbox"/> Coronary CTA		
<input type="checkbox"/> EKG		
<input type="checkbox"/> Other		

<input type="checkbox"/> TTE (Transthoracic Echo)	<input type="checkbox"/> TEE (Transesophageal Echo)	<input type="checkbox"/> Fetal Echo
Reason for Study (Check all that apply) <input type="checkbox"/> Abnormal Test Results (provide details below) <input type="checkbox"/> Acquired Pediatric Heart Disease <input type="checkbox"/> Aortic Disease <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Device Evaluation (Pacemaker, ICD, or CRT)	<input type="checkbox"/> Evaluate for cardiomyopathy (known/suspected) <input type="checkbox"/> Known or Suspected Fetal Cardiac Disorder <input type="checkbox"/> Murmur or click <input type="checkbox"/> Pericardial Disease <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Pre-op <input type="checkbox"/> Post-op	<input type="checkbox"/> Suspected Cardiac Mass <input type="checkbox"/> Suspected or Known Endocarditis <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Ventricular Function <input type="checkbox"/> Other (describe): _____ _____ _____

Symptoms with Suspected Cardiac Etiology (Check all that apply)

<input type="checkbox"/> Assess for structural heart disease	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Suspected Cardiac Source of Embolus
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Syncope	<input type="checkbox"/> Peripheral Embolic Event
<input type="checkbox"/> Dyspnea (Shortness of Breath)		<input type="checkbox"/> TIA /Stroke

ADL Limitations (list): _____

Other (describe): _____

Previous Tests	Date	Results
<input type="checkbox"/> TTE		
<input type="checkbox"/> TEE		
<input type="checkbox"/> Myocardial Perfusion Imaging (MPI)		
<input type="checkbox"/> MUGA		
<input type="checkbox"/> Cardiac MRI/CT		
<input type="checkbox"/> Coronary CTA		
<input type="checkbox"/> EKG		
<input type="checkbox"/> Other		

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.