



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? Ordering Physician Facility Other

Print Name: _____ Title: MD RN LPN PA NP 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.