CLEAR FORM

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:

☐ Consultation ☐ Office Visit ☐ Email ☐ Phone call with physician
☐ Hospital ☐ Prior surgery ☐ Prior Bone Density ☐ Unknown
☐ Other _____

What is the main reason(s) for requesting this ultrasound?

Has there been prior imaging for this condition? Select all that apply.

☐ No prior imaging ☐ Prior Ultrasound ☐ Prior CTA ☐ Prior CT
☐ Prior MRI ☐ Prior MRA ☐ Prior X-ray ☐ Don't know
☐ Other _____

When was the most recent imaging study performed?

☐ No prior imaging ☐ 1 month to less than 6 months ago ☐ Don't know ☐ 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

Have signs, symptoms, and/or physical exam findings developed or worsened since the most recent prior imaging study?

☐ No Prior Imaging ☐ Yes, physical exam findings have worsened ☐ Don't Know
☐ No ☐ Yes, new signs or symptoms have developed
☐ Yes, signs or symptoms have worsened ☐ 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.