



Ultrasound Testing Prior Authorization Form

Notification of Pregnancy Sent ?

Yes No

LMP: _____

EDC: _____

Date of Last USN: _____

Last Name: _____ First Name: _____

Member ID: _____ DOB / /

Ordering Physician _____ Contact Person _____

Office # _____ Fax # _____

Date of Request: / / Date of Procedure: / /

Site of Service Office Outpatient Center

DIAGNOSIS: _____

Type	Code	# USNs Requested and Frequency	Indication	History
<input type="checkbox"/> Ultrasound transabdominal, pregnant uterus, real time with image documentation fetal and maternal evaluation after first trimester	76805		<input type="checkbox"/> Basic dating <input type="checkbox"/> Basic screening anatomic survey Not for patients at elevated risk for fetal anomaly	
<input type="checkbox"/> Ultrasound First Trimester Transabdominal (Reflex 76817 TV if needed)	76801		<input type="checkbox"/> Vaginal bleeding/ pain <input type="checkbox"/> Dating & viability <input type="checkbox"/> Other:	HCG Value
<input type="checkbox"/> Ultrasound transabdominal, pregnant uterus, real time with image documentation fetal and maternal evaluation plus detailed fetal anatomic examination after first trimester	76811		<input type="checkbox"/> Vaginal bleeding/ placental location <input type="checkbox"/> Evaluation for abnormal biochemical markers <input type="checkbox"/> Previous congenital anomaly <input type="checkbox"/> Other:	Labs: Type of defect:
<input type="checkbox"/> Limited Ultrasound	76815		<input type="checkbox"/> Fetal position only <input type="checkbox"/> Placental position <input type="checkbox"/> AFI only (Quantitative) <input type="checkbox"/> Documentation of fetal heart beat	
<input type="checkbox"/> Follow-up Ultrasound	76816		<input type="checkbox"/> Evaluate growth <input type="checkbox"/> EFW <input type="checkbox"/> Re-evaluate anatomy <input type="checkbox"/> Follow-up fetal anomaly	
<input type="checkbox"/> Ultrasound Pregnant Transvaginal	76817		<input type="checkbox"/> Prior LEEP/ Prior PTD/ 2Δ loss <input type="checkbox"/> Cervical abnormality <input type="checkbox"/> Low lying placenta <input type="checkbox"/> Placenta previa <input type="checkbox"/> Evaluation for cervical insufficiency	Prior Cervical length ____ mm Gest age of previous loss or delivery _____ weeks
<input type="checkbox"/> Additional Fetus	76802 76810 76812		<input type="checkbox"/> Multiple gestations	Total # of fetuses: ____

Additional medical documentation may be required on a case by case basis.

COMMENTS:

Prior authorization is required once the number of ultrasounds have exceeded 2 in the pregnancy. These do not include those performed in an emergency department, as an inpatient, or in an urgent care setting. For urgent ultrasounds only, there is 3 business day grace period to submit this form after ultrasound is performed.

PLEASE REFER TO THE QUICK REFERENCE GUIDE ON OUR WEBSITE (WWW.BCHPOHIO.COM) FOR THE APPROPRIATE NUMBER FOR FAXING THIS FORM FOR PRIOR AUTHORIZATION