

United HealthCare Services, Inc. – Please attach completed form to [www.UHCProvider.com/paan](http://www.UHCProvider.com/paan) secure online request or fax to 1-855-352-1206. You may also call the toll-free number on your health plan ID card.

## 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					
<b>Chest Pain or suspected Angina with:</b> <i>(Check all that apply)</i>		<b>Associated Conditions:</b> <i>(Check all that apply)</i>		<b>Other Indications:</b> <i>(Check all that apply)</i>	
<input type="checkbox"/> Without other symptoms <input type="checkbox"/> Exacerbated by exercise or relieved by rest <input type="checkbox"/> Relieved with Nitroglycerin <input type="checkbox"/> Dyspnea (Shortness of Breath) <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Left Arm Pain/Radiating Pain <input type="checkbox"/> Retrosternal Location		<input type="checkbox"/> Abnormal EKG <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Known CAD <input type="checkbox"/> New Onset Heart Failure <input type="checkbox"/> Patient has one or more of the following: heart transplant, aortic aneurysm, and/or carotid narrowing/stenosis		<input type="checkbox"/> Abnormal Test Results <i>(Please provide detail in previous test grid below)</i> <input type="checkbox"/> Anomalous coronary artery <input type="checkbox"/> Congenital heart disease (known/suspected) <input type="checkbox"/> Evaluation for myocardial viability <input type="checkbox"/> Pediatric Acquired Heart Disease <input type="checkbox"/> Suspected Constrictive Pericarditis <input type="checkbox"/> Quantification intracardiac shunt <input type="checkbox"/> Quantification valvular regurgitation	
<b>Risk Factors for Coronary Artery Disease: (Check all that apply)</b>					
<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
<b>Reason for Study (Check all that apply)</b> <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.**