Children's Heart Center
**Outpatient Diagnostic Services**
1200 CHILDREN'S AVENUE, SUITE 2F
OKLAHOMA CITY, OK 73104
PHONE: 405.271.5918

# Echo Lab Services Referral Request

**Attn: Scheduling Team**
**Tel: 405.271.5918 – Option 1**

**FAX COMPLETED REQUEST TO:**
**405.271.1162**

**(Please Print)**

## Patient Information

| Last Name | First Name | MI | Date of Birth | Age | M/F |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Parent/Guardian Name | Relationship to Patient | Preferred Contact Number: ☐ Cell ☐ Home |
|---|---|---|
| | | |

## Ordering Provider Information

| Full Name | ☐ MD ☐ DO ☐ NP ☐ PA | Provider Contact # |
|---|---|---|
| | | |

| Ordering Provider Signature | Office Staff Contact Name and Follow-Up # |
|---|---|
| | |

Practice Name and Address

**To avoid delays in order processing, NP's and PA's are requested to provide the name of their supervising MD/DO below.**

| Supervising MD/DO Name | ☐ MD ☐ DO | Contact #: ☐ Cell ☐ Office Phone |
|---|---|---|
| | | |

## Echo Service Requested (check the appropriate box below)

☐ Transthoracic Echocardiogram with or without Congenital Anomaly **(CPT 93303-93308 + 93320-93325)**

**List the key clinical indications/symptoms that support the medical necessity for the requested services.**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **ICD10** | | | | . | | | | | (enter a minimum of 3 and maximum of 7 characters) |
| **ICD10** | | | | . | | | | | (enter a minimum of 3 and maximum of 7 characters) |

## Insurance Information

| Payer Type | ☐ HMO | ☐ PPO | ☐ Medicaid | ☐ Medicare | ☐ Tricare | ☐ Self-Pay |
|---|---|---|---|---|---|---|
| | ☐ Other (specify): | | | | | |

| Guarantor Name | Relationship to Patient | Contact Number: ☐ Cell ☐ Home |
|---|---|---|
| | | |

**The support documents listed below must accompany this request at the time of submission.**

- ☐ Face-sheet with patient demographics, including patient, next-of-kin, guarantor and insurance information
- ☐ Referral form verifying eligibility, period of coverage and reason for subspecialty care (if required by payer)
- ☐ Most recent clinic note(s) and pertinent diagnostic results (e.g., EKG, Lab, X-Ray, etc.)
- ☐ Legible copy of both sides of the patient's insurance card

## Prior-Authorization Information (For Internal Use Only)

Prior-authorization of requested services will be obtained by the Children's Heart Center Support Team.

| Authorization # | Approved # of Visits | Expiration Date |
|---|---|---|
| | | |