400 Buckwalter Place Blvd
Bluffton, SC 29910

Phone: 1(888) 333-9036
Fax: 1 (888) 785-2487

GENERAL CLINICAL CERTIFICATION REQUEST FORM

PLEASE USE THIS FORM FOR **MRI/MRA, CT/CTA and Nuclear Cardiology**

PLEASE BE ADVISED THAT ALL QUESTIONS SHOULD BE ANSWERED COMPLETELY. FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST

Patient Name____**DOB**_________________________

Patient Address________________________________**City**__________________**State**___**Zip**_______

Insurance Plan__________________________________**Subscriber ID**_________________________

Referring Physician ______________________________**Specialty**______________________________

Physician Address_______________________________**City**_______________________**State**________

Physician Fax #(___)____________________________**Phone #(___)**__________________________

Date of Request_________________________________**Contact Person**________________________

Imaging Site Name______________________________**Site Phone #(___)**______________________

Site Address____**City**____________________**State**_______

CPT codes requested:

CPT CODE	DESCRIPTION

Diagnosis if known____ **ICD-9 Code**_______________

Rule out diagnosis_______________________________________ **Date of last office visit**______________

Symptoms/Complaints:

Symptom or Complaint	Duration

Patient Name____

Patient ID____

Findings on physical Exam :

Prior Tests (including X-ray,CT, MRI, PET,US, Biopsy etc) for current problem

Test	Date	Results

Treatment for current problem:

Treatment	Duration of treatment	Effective (Yes/No)

Is there any additional history or clinical facts supporting the requested examination. Use additional sheets if needed.

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Physician's Signature____**Date**_________________________