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GENERAL CLINICAL CERTIFICATION REQUEST FORM

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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.

Physician's Signature _____ Date _____