



**CT/CTA CLINICAL CERTIFICATION REQUEST FORM**  
 FAX: 800.540.2406

Please be advised that all questions must be answered completely.  
 Failure to do so may delay a determination.

<b>Patient name:</b>		<b>DOB:</b>	
<b>Insurance plan:</b>		<b>Member ID #:</b>	
Referring physician:	Dr.	Specialty:	
Physician address:			
	City, state, zip:		
Physician fax #:		Physician phone #:	
Date of request:		Contact person:	
Imaging facility:	Name	Site phone #:	
Site address:			
	City, state, zip:		
Diagnosis, if known, or rule out:			
Requested CPT code:		CPT code description:	
ICD-9 code		Date of last office visit	/ /

**SYMPTOMS/COMPLAINTS:**

Symptoms and complaints	Duration

**FINDINGS ON PHYSICAL EXAM (include provocative tests if applicable):**




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**PRIOR TESTS (including x-ray, US, CT, MRI); treatments (surgery, physical therapy etc); biopsy results related to the current problem:**

Test, intervention or surgery	Date	Results

**RESULTS OF PERTINENT RECENT LAB TESTS RELEVANT TO THE CURRENT PROBLEM:**

Test	Date	Result

**MEDICATIONS USED FOR THE CURRENT PROBLEM:**

Medication	Duration and dates	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 \_\_\_\_\_