



MR/MRA 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.**

Patient name:		DOB:	
Insurance plan:		Member ID #:	
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, sip:	
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.

Physician's signature _____ Date _____