



OBSTETRICAL ULTRASOUND 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, zip:		

Proposed date of service	CPT code(s)	Gestational age

Patient age at delivery		Number of gestations	circle one: 1	2	3	4
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Reason for risk for pre-term labor			
Cervical length on last ultrasound		Current symptoms	
Results and dates of prior laboratory tests			
Maternal medical problems			
Maternal medications			
History of prior pregnancy complications or congenital anomalies			
Estimated gestational weight		US estimated gestational age	
Documented fetal anomalies in this pregnancy			
Results of prior ultrasound exams			
Other pertinent information			

Signature of requesting physician _____ **Date** _____