

**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 THE DECISION.**

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)

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):

Patient Name: _____
 Member ID #: _____

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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** _____