

MR/MRA CLINICAL CERTIFICATION REQUEST FORM

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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 _____ Specialty _____

Physician Address _____ City _____ State _____

Physician Fax # (____) _____ Phone # (____) _____

Date of Request _____ Contact Person _____

Imaging Facility Name _____ Site Phone # (____) _____

Site Address _____ City _____ State _____

Requested CPT Code _____ CPT Code Description _____

Diagnosis, if known, or Rule-out _____

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 _____