400 Buckwalter Place Blvd
Bluffton, SC 29910

Phone: **1 (888) 333-9036**
Fax: **1 (888) 785-2487**

GENERAL CLINICAL CERTIFICATION REQUEST FORM

PLEASE USE THIS FORM FOR **MRI/MRA, CT/CTA and Nuclear Cardiology**

ALL QUESTIONS SHOULD BE ANSWERED COMPLETELY. FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST.

Patient Name_____ **DOB**_____

Patient Address_____ **City**_____ **State**___ **Zip**_____

Insurance Plan_____ **Subscriber ID**_____

Referring Physician _____ **Specialty**_____

Physician Address_____ **City**_____ **State**_____

Physician Fax #(___)_____ **Phone #(___)**_____

Date of Request_____ **Contact Person**_____

Imaging Site Name_____ **Site Phone #(___)**_____

Site Address_____ **City**_____ **State**_____

CPT codes requested:

CPT CODE	DESCRIPTION

Diagnosis, if known_____ **ICD-9 Code**_____

Rule out diagnosis_____ **Date of last office visit**_____

Symptoms/Complaints:

Symptom or Complaint	Duration

Patient Name_____

Patient ID_____

Findings on physical exam:

Prior tests (including X-ray, CT, MRI, PET,US, Biopsy etc) for current problem:

Test	Date	Results

Treatment for current problem:

Treatment	Duration of treatment	Effective (Yes/No)

Is there any additional history or clinical facts supporting the requested examination? Use additional sheets if needed.

_____

_____

_____

_____

_____

Physician's Signature_____Date_____