CULLMAN REGIONAL

RADIOLOGY OUTPATIENT PRECERTIFICATION REQUEST FORM

Fax to: (256) 585-6319 Phone: (256) 737-2667

Fax this page along with the order, insurance information, and last clinic note (if available).

REQUESTING PHYSICIAN INFORMATION:

NPI#:

PATIENT INFORMATION

Name: _____ DOB: _____/_____/_____

Examination Requested: _____

Examination Requested: _____

Examination Requested: _____

Anticipated Date of Service: _____

MEDICAL INFORMATION

1. Symptoms and their duration (Reason the study is being requested): _____

_____

2. Conservative treatment patient has already completed (please note for how long)
   - ☐ Physical Therapy _____
   - ☐ Chiropractic therapy _____
   - ☐ Medications _____
   - ☐ Other _____
   - ☐ Ice packs/hot packs _____
3. Preliminary procedures already completed: (note date performed and results)
   - ☐ CT _____
   - ☐ Ultrasound _____
   - ☐ Other _____
   - ☐ X-rays _____
   - ☐ Lab Work _____
4. Co-morbid Conditions:
   - ☐ Diabetes
   - ☐ Hypertension
   - ☐ Other _____
   - ☐ Coronary Artery Disease
   - ☐ Peripheral vascular disease

Precertification Information Only

Case # _____ **Auth #** _____

Reference # _____ **Expires:** _____

Notes:

Auth # _____

Expires: _____

Auth # _____

Expires: _____

REV. 7/2026