RADIOLOGY OUTPATIENT PRECERTIFICATION REQUEST FORM

Fax to: **(256) 737-2176** Phone: (256) 737-2175

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:_______________________________