Clinical Certification Request Form (CT, CTA, MRI, MRA, Nuclear Medicine)

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE**.

Patient/Member

First Name:	Middle Initial:	Last Name:	
DOB (*mm/dd/yyyy*):		Gender: ◯ Male ◯ Female	
Street Address:			Apt #:
City:		State:	Zip:
Home Phone:	Cell Phone:		Primary Contact: ◯ Home ◯ Cell
Health Plan:	Member ID:		Group ID:

Ordering Provider

First Name:		Last Name:	
Primary Specialty:	TIN:		NPI:
Physician Phone:		Physician Fax:	
Address:			Suite #:
City:		State:	Zip:
Office Contact:			Ext:
Contact Email:			

Facility/Site

First Name:		Last Name:	
Group/Site Name:			
Primary Specialty:	TIN:		NPI:
Site Phone:		Site Fax:	
Address:			Suite #:
City:		State:	Zip:

Diagnosis

Diagnosis, if known or rule out:	
Requested CPT Code:	CPT Code Description:
ICD-10 Codes:	
Date of last visit:	

Clinical Information

Symptoms and Complaints:	Duration:

Findings on Physical Exam (include provocative tests if applicable):

Patient/ Family History Applicable to Imaging Request:

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:

If Preoperative, List Surgery or Procedures Planned:	Date:

Clinical Information

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
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No
		◯ Yes ◯ No

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

Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: