169 Myers Corners Road
Wappingers Falls, NY 12590
Phone: (866) 496-6200
Fax: 1-800-637-5204
www.carecorenational.com

Date: _____

Number of Pages: _____

To: (Physician Name) _____

From: (Patient Name) _____

Fax: _____

Attached please find a copy of the written clinical certification request form

for: (Patient Name) _____

Please complete in full and return to CareCore National **1-800-637-5204** with a legible copy of the relevant part of the patient's medical records to expedite the certification process. Clinical office notes, consultation reports, or a signed and dated clinical summary outlining the indications for the requested study from the requesting physician are acceptable.

Please retain a copy of the form for future use.

Thank you for your cooperation,

CareCore National, LLC
Imaging Care Management Unit

VISIT US AT WWW.CARECORENATIONAL.COM FOR INFORMATION ABOUT HOW TO ACCESS OUR NEW WEB PRE CERTIFICATION PROCESS, VERIFY AUTHORIZATIONS AND LEARN MUCH MORE ABOUT CARECORE NATIONAL.

CLINICAL CERTIFICATION REQUEST FORM

Please use this form if you cannot fax copies of patient progress notes.

PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED COMPLETELY (FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST).

Patient Name: _____ D.O.B.: _____

Insurance Plan: Horizon BCBSNJ Subscriber ID: _____

Referring Physician: _____ Specialty: _____

Physician Address: _____ City: _____ State: _____ Zip: _____

Physician Fax #: (_____)_____ Phone #: (_____)_____

Date of Request: _____ Contact Person: _____

Imaging Facility Name: _____ Site Phone #: (_____)_____

Site Address: _____ City: _____ State: _____ Zip: _____

Test Requested: _____ CPT Code: _____

1. What is the working diagnosis? _____ Rule out: _____
2. What are the patient's symptoms?_____
3. How long has the patient had these symptoms?_____
4. Please enter the date of the most recent office visit and the findings at that visit: _____

_____

_____

5. Enter results of any prior diagnostic testing for this problem.

   Test: _____ Date: _____ Results: _____

   Test: _____ Date: _____ Results: _____

   Test: _____ Date: _____ Results: _____

6. List any medications and/or treatment for these symptoms.

   Medications: _____ Date started: _____ Effective? Yes__ No__

   Medications: _____ Date started: _____ Effective? Yes__ No__

   Medications: _____ Date started: _____ Effective? Yes__ No__

   Treatments: _____ Date started: _____ Effective? Yes__ No__

   Treatments: _____ Date started: _____ Effective? Yes__ No__

Is there any other history or clinical facts supporting this requested examination? Use additional sheets if necessary.

_____

_____

_____

_____

Physician's Signature: _____ Date: _____