



**GENERAL USE CLINICAL CERTIFICATION REQUEST FORM**  
**AvMed Health Plans Fax: 800.540.2392**



Please be advised that all questions should be answered completely.

<b>Patient name:</b>		<b>DOB:</b>	
<b>Insurance plan:</b>		<b>Member ID #:</b>	
Referring physician:	Dr.	AvMed Physician ID #:	
Physician address:		Specialty:	
City, state, zip:			
Physician fax #:		Physician phone #:	
Date of request:		Contact person:	
Imaging facility:	Name	AvMed Facility ID #:	
Facility address:			
City, state, zip:		Facility phone #:	
ICD-9 code/description			
Requested CPT code:		CPT code description:	
Date of last office visit (MM/DD/YYYY):	/	/	

**SYMPTOMS/COMPLAINTS:**

Symptoms and complaints	Duration

**FINDINGS ON PHYSICAL EXAM (include provocative tests if applicable):**




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**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

**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

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

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Physician's signature \_\_\_\_\_ Date \_\_\_\_\_