CMO
MONTEFIORE CARE MANAGEMENT

MRA/MRI CLINICAL CERTIFICATION REQUEST FORM

Date of Request: ____________________________

Patient Name:
Patient Address:
City: **State:**
Patient Phone #:
Member ID #: **DOB:**
Insurance Plan:

Referring Physician:
Physician Address:
City: **State:**
Physician Phone #:
Physician Fax #:

Is the condition a result of a motor vehicle accident? ☐ Yes ☐ No	Is the condition a result of a work-related incident? ☐ Yes ☐ No

Imaging Facility Name:
Site Address:
City: **State:**
Site Phone # :
Site Fax #:

Requested CPT/Exam:
ICD-9:
Diagnosis:
Is this a rule out? ☐ Yes ☐ No

Symptoms and Complaints (Include duration):

Physical Limitations and Findings:

Neurological Findings:

How has the problem been treated thus far and for how long? (Include PT/Medications/Tests)

Other information you believe relevant:

How will this test result change your current treatment plan?

Physician's signature: **Date:**

PLEASE ANSWER ALL QUESTIONS COMPLETELY, AS FAILURE TO DO SO MAY DELAY THE DECISION.

Payment of claims associate with this referral is subject to all contract terms, benefit limitations and exclusions, including eligibility of benefits on the date of service.

Radiology Line (866) 666-8388 Radiology Fax Line (914) 457-9509

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