VIVA HEALTH

IMAGING REQUEST PRECERTIFICATION FORM

Fax to: 205.449.7049

For **NON-URGENT** requests, please fax this completed document along with medical records, imaging, tests, etc.

For URGENT Requests Call - 205.933.1201

MEMBER	**Name:**
	DOB:
	Member #:
PROVIDER	**Ordering MD:**
	MD NPI:
	Person Completing Form:
	Phone #:
	Return Fax #:
FACILITY	**Facility Name:**
	Facility NPI:
	Phone #:
DIAGNOSIS	**Diagnosis or Rule Out Diagnosis:**
	ICD-10 Codes:
	Date of last visit:
PROCEDURE	**List all applicable CPT Codes:**
CLINICAL INFORMATION	**1. Symptoms (include duration, frequency, intensity)**
	2. What does MD suspect or is ruling out w/requested study?
	3. List treatment received for above symptoms (include duration and type)
	4. List previous relevant testing (i.e. labs, diagnostic imaging, other tests & results)
	5. Is this injury related? YES or NO
	If yes, date/type of injury:
	6. Is study part of a standard post-chemo/radiation protocol w/prior cancer dx? YES or NO
	If yes, type of cancer:

This approval does not authorize services not covered by the benefits currently provided under the member's benefit plan. For the services to be covered, the member must be enrolled and effective at the time the service is provided.