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Wappingers Falls, NY 12590
Phone: (845) 298-8155
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Clinical Certification Request Form

Please retain a blank copy of the form for future use.

Date: _____ Number of pages: _____

To: Physician Name: _____

Re: Patient Name: _____ Fax : _____

Attached please find a copy of the written clinical certification request form for your Horizon Blue Cross Blue Shield of New Jersey patient: (Patient Name) _____

Please complete the following form in full and fax it to CareCore National **1-845-297-3896** with a legible copy of the relevant part of the patient's medical records to expedite the clinical 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.

Thank you for your cooperation,
CareCore National, LLC Imaging Care Management Unit

Visit us at WWW.CARECORENATIONAL.COM for information about how to access about our new web pre-certification process, verify authorizations and learn much more about CareCore National.

CONFIDENTIALITY NOTICE: The attached information to this facsimile transmission is CONFIDENTIAL and is intended only for the use of the recipient(s) identified above. It may contain confidential and protected health information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are not the intended recipient or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is STRICTLY PROHIBITED. If you have received this transmission in error, please notify sender immediately by telephone and destroy the transmission and its attachments without saving them in any manner.

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

Patient Name: _____ DOB _____ Insurance Plan; **Horizon BCBSNJ**

Subscriber ID _____

Referring Physician: _____ Specialty _____

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

Physician Address: _____
Street City State Zip

Date of Request: _____ Contact Person: _____

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

Site Address: _____
Street 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 ___

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

CPT	DESCRIPTION	CPT	DESCRIPTION	CPT CODES AND CORRESPONDING G CODES
72131	CT L S W/O CONTRAST	73221	MRI UPPER EXTREMITY JOINT W/O CONTRAST	
72132	CT L SPINE W/CONTRAST	73222	MRI UPPER EXTREMITY JOINT W/ CONTRAST	CPT CODE 78459
72133	CT L SPINE W/O&W/CNTR	73223	MRI UPPER EXTREMITY JOINT W/&W/O CONTRAST	G0230
70552	MRI HEAD W/CONTRAST	73718	MRI LOWER EXTREM OTHER THAN JOINT W/O C	CPT CODE 78491
70553	MRI HEAD W/&W/O CNTRST	73719	MRI LOWER EXTREM OTHER THAN JOINT W/CONT	G0030, G0032, G0034, G0036, G0038, G0040, G0042, G0044, G0046
72141	MRI CERV SPINE W/O CONTR	73720	MRI LOWER EXTREM OTHER THAN JOINT W/&W/O	
72142	MRI CERVICAL SPINE W/CNTR	73721	MRI LOWER EXTREMITY JOINT W/O CONTRAST	CPT CODE 78492
72146	MRI THOR SPINE W/O CNTR	73722	MRI LOWER EXTREMITY JOINT W/ CONTRAST	G0031, G0033, G0035, G0037 G0039, G0041, G0043, G0045, G0047
72147	MRI THOR SPINE W/CNTR	73723	MRI LOWER EXTREM JOINT W & W/O CONTRAST	
72148	MRI LUMB SPINE W/O CNTR	76093	MRI BREAST WITH AND/OR WITHOUT CONTRAST	CPT CODE 78608
72149	MRI LUMB SPINE W/CNTR	76094	MRI BREAST BILATERAL	G0229
72156	MRI C SPINE W/&W/O CNTR	78459	MYOCARDIAL IMAGING (PET SCAN) G0036, G0037	CPT CODE 78810
72157	MRI T SPINE W/&W/O CNTR	78491	MYOCARDIAL IMAGING (PET SCAN)	G0125, G0210, G0211, G0212, G0213, G0214, G0215, G0216, G0217, G0218, G0219, G0220, G0221, G0222, G0223, G0224, G0225, G0226, G0227, G0228,
72158	MRI L SPINE W/ & W/O CONTRAST	78492	MYOCARDIAL IMAGING (PET SCAN)	G0231, G0232, G0233, G0234, G0252, G0253, G0254, G0296
73218	MRI UPPER EXTREMITY OTHER THAN JOINT W/O	78608	BRAIN IMAGING (PET SCAN)	
73219	MRI UPPER EXTREMITY OTHER THAN JOINT W/	78609	BRAIN IMAGING (PET SCAN)	
73220	MRI UPPER EXTREM OTHER THAN JOINT W/&W/O	78810	TUMOR IMAGING (PET SCAN)	

Please note: CPT codes not referenced on this form are not excluded from Clinical Certification requirements.

Use additional sheets if necessary. To be accepted, this document **must** be signed by the ordering physician:

Physicians Signature: _____ Date: _____