



**Radiology Advanced Imaging Program
Phase Two Benefit Certification
Clinical Information and Fax Form**

Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) are providing this optional form for use with the Advanced Imaging Ordering Program. It can be used as a tool when calling HealthHelp or it can be filled out and faxed to 1-888-717-9655.

Date (dd/mm/yyyy)		Time	
Office Contact Name		Office Contact Phone Number	
Patient Name Last/First/Initial		Patient ID Number	
Date of Birth dd/mm/yyyy		Group Number	
Ordering Physician Name (Last/First)		Physician Phone Number	
Name of Radiology Facility		Radiology Facility Fax Number	

Procedure Name and Code: _____

CPT Code: ____ . ____

Patient Diagnosis and Code: _____

CPT Code: ____ . ____

Patient Symptoms and Duration: _____

Medications, Duration, Effect: _____

Prior Imaging Studies and Results: _____

Prior Laboratory Studies and Results: _____

Please attach any additional relevant clinical information.

*******CONFIDENTIALITY NOTICE*******

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