FIRELANDS Regional Medical Center

Request for Imaging, Sleep Lab & Echocardiogram Precertification

FAX COMPLETED FORM AND ORDER TO 419-557-6541

For questions, call 419-557-5493 or 419-557-5494. ***Please allow 2 business days.***

Date: _____ Ordering Physician Full Name: _____ Physician Phone #: _____

Physician NPI#: _____ Physician TIN#: _____

Patient Name: _____ Patient DOB: _____ SSN: _____

Patient Height: _____ Patient Weight: _____

Location Preference:

☐ Firelands Regional Medical Center Main Campus
1111 Hayes Avenue, Sandusky

☐ Firelands Regional Medical Center Imaging Center
2500 W. Strub Road, Suite 130, Sandusky

Primary Insurance Carrier & Plan Name: _____ Policy #: _____ Group #: _____

Secondary Insurance Carrier & Plan Name: _____ Policy #: _____ Group #: _____

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF THE PATIENT'S INSURANCE CARD(S). CLINICAL NOTES PERTAINING TO THE REASON FOR THE ORDERED TEST ARE REQUIRED FOR COMPLETION OF PRE-CERTIFICATION

Diagnosis / ICD-10/ Reason for Visit: _____

Test(s) to be performed *(CPT Code(s)):* _____

PREVIOUS TESTS PERFORMED, INCLUDING PERTINENT LABS, PHYSICAL THERAPY, HOME EXERCISE, ETC.:

DATE	TEST / PROCEDURE	RESULTS

Patient Medications / Duration *(including NSAIDs):* _____

Worker's Comp? Y / N Sport's Injury? Y / N McMurrary Test Positive? Y / N

CARDIAC PATIENTS *(Please Circle):*

Diabetes? Y / N Smoker? Y / N Hypertension? Y / N Family Hx Heart Disease? Y / N

NOTE: please note that we will make all attempts to obtain an authorization in a compliant fashion, but some insurance companies require the physician office to complete this process.

CONFIDENTIAL: ALL INFORMATION ON THIS DOCUMENT IS CONFIDENTIAL.