UnitedHealthcare
A UnitedHealth Group Company

MR/MRA NOTIFICATION REQUEST FORM

Date: ______________________________

Number of Pages: ___________________

Fax: ______________________________

Patient Name____ **DOB**________________

Subscriber ID____________________________ **Group Number**___________________

Referring Physician_______________________ **Physician TAX ID#**_________________

Physician Address____

City_____________________________________ **State**____

Physician Fax Number ________________________________

Physician Phone Number_______________________________

Contact Name _______________________________________

Requested CPT/Exam_______________________________________ **ICD9** __________

1. What is the working diagnosis____________________ Rule out ____________________________

Symptoms/Complaints:

Symptoms and Complaints	Duration

Findings on physical Exam (include provocative tests if applicable):

Subscriber ID ___________
Group Number ___________

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Prior Tests (including x-ray, US, CT, MRI), Treatments (surgery, physical therapy etc), Biopsy results related to the current problem:

Test, Intervention or Surgery	Date	Results

Results of pertinent recent lab tests relevant to the current problem:

Test	Date	Result

Medications used for the current problem:

Medication	Duration and dates	Effective Yes/No

2. Is there other history or clinical facts supporting this requested examination? Use additional sheets if necessary.____

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Physician's Signature ________________________________ **Date** ______________

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

Please fax this form, along with any additional documentation, to UnitedHealthcare at 1-866-889-8061.

Please call 1-866-889-8054 if you have any questions.