CT Scheduling Questions/Requirements

Please refer to this form when scheduling a CT Scan

UMMHC NPI# 1831151455

BUN _____CREAT_____ GFR_____ Date _____

Allergies ☐ **Yes** ☐ **No**

Diabetes ☐ **Yes** ☐ **No**

Hypertension ☐ **Yes** ☐ **No**

Renal Disease ☐ **Yes** ☐ **No**

Power Port ☐ **Yes** ☐ **No**

Is Patient coming from a facility ☐ **Yes** ☐ **No**
Is patient Patient over 65 ☐ **Yes** ☐ **No**
Interpreter Needed ☐ **Yes** ☐ **No**

If yes, Language: _____

Prior Auth_____ Eff Date: _____ Exp Date: _____

If no prior auth is needed list Name of person you spoke with_____

Phone Number Called: _____

Reference Number: _____

Type of CT Scan being requested:_____

- with contrast
- without contrast
- with and without contrast
- need signs, symptoms and what the doctor is ruling out
- *Example: CT Lumbar Spine with contrast for back pain L4-L5 r/o spinal stenosis*