Diagnostic Testing Request Form

[Insert name of practice/department here]

The purpose of this form is to provide medically necessary reasons to support reimbursement by payers for diagnostic testing interpretations performed by **[Insert provider name and practice name/group here]**.

You must provide an ICD-9CM code at the highest level of specificity in order for the test to be submitted for reimbursement to a carrier. ***Any request forms not properly completed will be sent back to the ordering provider for clarification and/or correction.***

1. Test to be ordered ___________________________________ (please provide either the complete test name to be performed or the appropriate CPT® or HCPCS II Code)
2. Reason for the test being ordered ____________________________(please provide the ICD-9CM code at the highest level of specificity for ordering this test)

Signature of the ordering provider: ____________________________________

Printed Name of the ordering provider: _________________________________

Department of ordering provider: ______________________________________

Date ordered: ____

For Internal Use Only:

Provider Name Reviewing Diagnostic Test: ___________________________________

The ordering provider provided the proper CPT® or HCPCS II code: ___ Yes ___No

The ordering provider provided the proper ICD-9CM code: ___ Yes ___No

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