

**CLINICAL INFORMATION FAX FORM FOR
HUMANA PATIENTS**

Member Name _____ **Member ID#** _____

Ordering Physician Name _____

Address _____

Telephone Number _____ **Fax Number** _____

Patient Diagnosis/Clinical Indication (ICD-9 Code) _____

Test Being Ordered _____

Patient Symptoms/Duration _____

Prior Imaging Studies _____

Laboratory Studies _____

Patient Medications/Duration _____

Prior Treatments _____

Please fax the clinical information form to (888)863-4464. A friendly coordinator will contact you regarding the test that is being ordered. Thanks.