





**Scan request**

Name of radiology practice

Referring doctor's name

Referring doctor's speciality

Scan type requested

Please provide motivation/reason

MRI scan  Tarrif/CPT Code

Description

CT scan  Tarrif/CPT Code

Description

**ACKNOWLEDGEMENT BY EXAMINING DOCTOR**

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Having conducted a personal medical examination, I certify that the particulars are, to the best of my knowledge and belief, true and accurate . I acknowledge that the Insurer will rely on such particulars when making any recommendations regarding the payment of treatment and services.

Doctor's last name

Doctor's first name(s)

Doctor's signature

Date

**PATIENT'S DECLARATION**

I hereby declare that the information in this form is true and correct. I am aware that the Insurer may request medical information from any medical facility, laboratory, clinic, hospital, doctor or specialist that it requires.

In order to fully assess this application for benefits, I hereby give my consent for the Insurer to obtain this information. I understand that this application is subject to the Liberty Health Cover Policy Conditions and benefits.

Patient's signature

Date