Prior Authorization Form Outpatient Imaging

Phone: (866) 422-2204 | Fax: (800) 398-1388

☐ **URGENT – 1 Business day** ☐ **ROUTINE – 3 Business days**

Request Date: ________________ ☐ Male ☐ Female

Patient Name: ______________________________ **DOB**: ________________

Patient Address: ______________________________ Phone: ________________

City: ______________________________ Zip Code: ________________

Health Plan: ______________________________ **Member ID:** ________________

Referring Physician (Print): ________________ **Specialty**: ____________ PCP (Print): ____________

(If Different from Referring Physician)

Diagnosis: ______________________________ ☐ Iodine Allergy ☐ Pacemaker

Procedure Requested: ________________ ________________

________________ ________________

Description/Pertinent Clinical Information: ______________________________

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→TO EXPEDITE PROCESS - PLEASE ATTACH CLINICAL DOCUMENTATION/LABORATORY/IMAGING/CONSULTS

☐ Pertinent Labs Included ________________ ☐Pertinent Radiology Exams Included ________________

☐ Clinical Notes Included ________________ ☐ Consult Included by Dr. ________________

IMAGING CENTER LOCATION (SELECT FROM REVERSE SIDE)

Please indicate your preferred location: ______________________________

PRE-AUTHORIZATION REQUEST INFORMATION (PLEASE FAX OFFICE NOTES WITH FORM)

Please check appropriate box:

☐ PET/CT ☐ MRA ☐ MRI ☐ CTA ☐ CT ☐ Nuclear Medicine ☐ Surgical

☐ With Contrast ☐ Without Contrast ☐ With and Without Contrast ☐ Contrast at Radiologist's Discretion

Body Part: ______________________________

Procedure/CPT Code: ________________ Diagnosis Code (ICD-10) ________________

Reason for Procedure: ______________________________

Physician Signature:________________ **Phone**: (   )__________ **Fax**: (   )__________

Contact Person: ________________ Total No. Pages Included in Fax: ________________

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