Arizona Priority Care

*One Goal. One Priority. Your Healthcare.*

iSELECT

# 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**: _____

_____

**→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:

☐ 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: _____