



72 West Jimmie Leeds Road, Suite 1100
 Galloway, New Jersey 08205
 Phone: 855-677-9729
 Fax: 855-677-9783

AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION (PLEASE INCLUDE PATIENT DEMO SHEET, IF AVAILABLE)

Patient Name: _____ DOB: ____/____/____ Gender (Circle): M F
 Address: _____
 City: _____ State: _____ Zip Code: _____ Phone: ____-____-____
 Insurance Company Name: _____ Policy ID #: _____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____
 Fax #: _____
 INS Provider / Tax ID#: _____
 Diagnosis 1: _____ ICD10 Code 1: _____
 Diagnosis 2: _____ ICD10 Code 2: _____
 Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): (MANDATORY)

 Findings from prior radiology exams: _____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

EXAM TYPE: MRI MRA
 With & Without Contrast Without Contrast
 With Contrast

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Sinuses
<input type="checkbox"/> Brachial Plexus	Duration of symptoms _____
<input type="checkbox"/> Brain	Type of antibiotics _____
Hormone Levels _____	Duration of antibiotics _____
<input type="checkbox"/> Breast, Bilateral	<input type="checkbox"/> C Spine
<input type="checkbox"/> Breast, Bilateral Implant Evaluation	<input type="checkbox"/> L Spine
<input type="checkbox"/> Breast, Bilateral Cancer Evaluation	<input type="checkbox"/> T Spine
<input type="checkbox"/> Chest	<input type="checkbox"/> Ankle Rt ____ LT ____
<input type="checkbox"/> MRCP	<input type="checkbox"/> Elbow Rt ____ LT ____
<input type="checkbox"/> Neck	<input type="checkbox"/> Foot Rt ____ LT ____
<input type="checkbox"/> Orbits	<input type="checkbox"/> Hand Rt ____ LT ____
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Hip Rt ____ LT ____
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Knee Rt ____ LT ____
<input type="checkbox"/> Other	<input type="checkbox"/> Shoulder Rt ____ LT ____
	<input type="checkbox"/> Wrist Rt ____ LT ____
	CPT Code: _____

EXAM TYPE: CT CTA
 With & Without Contrast Without Contrast
 With Contrast

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Neck	<input type="checkbox"/> C Spine
<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Orbits	<input type="checkbox"/> L Spine
<input type="checkbox"/> Brain	<input type="checkbox"/> Pelvis	<input type="checkbox"/> T Spine
<input type="checkbox"/> Carotid	<input type="checkbox"/> Pituitary	
<input type="checkbox"/> Chest	<input type="checkbox"/> Sinuses	
<input type="checkbox"/> Coronary CTA	Duration of symptoms _____	
<input type="checkbox"/> Head	Type of antibiotics _____	
<input type="checkbox"/> Heart	Duration of antibiotics _____	
<input type="checkbox"/> Kidney		
<input type="checkbox"/> Urography		
<input type="checkbox"/> Upper Extremity _____		
<input type="checkbox"/> Lower Extremity _____		
Date of Injury: ____/____/____		
Date of onset of symptoms: ____/____/____		
Date of PT start: ____/____/____		
Medications: _____		
<input type="checkbox"/> Other _____ CPT Code: _____		
<input type="checkbox"/> With 3D Recons		

Please notify me _____ days before authorization expiration.

Submitted by: _____ Phone #: _____ Date: ____/____/____

4 Fax completed forms to: 855-677-9783