Radiology Imaging Pre-Authorization Request Form

Patient Information

Full Name

Date of Birth

Member ID

Phone Number

Address

Provider Information

Referring Provider Name

Provider NPI

Phone

Fax

Insurance Information

Insurance Name

Group Number

Plan Name

Authorization Number

Imaging Request Details

Type of Imaging

Body Part

ICD-10 Diagnosis Code(s)

CPT Code(s) Requested

Clinical Indication/Reason for Study

Additional Information

Previous Relevant Imaging (Date/Type/Facility)

Notes / Comments