SJRA SOUTH JERSEY RADIOLOGY

AUTHORIZATION REQUEST FORM

Please fax this completed form along with medical records, imaging tests, and order for exam to **877-211-9603**

We are unable to obtain precertification for URGENT/STAT requests, No-fault (MVA), Workers Compensation and /or non-participating insurance carriers.

SJRA NPI# 1477551653

Patient Information

First Name:	Middle Initial:	Last Name:
DOB (mm/dd/yyyy)		Gender: ☐ Male ☐ Female
Address:		Apt#:
City:	State:	Zip:
Patient Phone Number:		
Health Insurance Plan:		
Member ID:		Group ID:
COPY OF INSURANCE CARD REQUIRED (front & back)	**COPY OF PRESCRIPTION/ ELECTRONIC ORDER REQUIRED**	

Ordering Provider

First Name:		Last Name:
Primary Specialty:	TIN:	Individual NPI:
Provider Phone:	Ext:	Provider Fax:
Address:		Suite Number:
City:	State:	Zip:
Office Contact:		Email:

Diagnosis and Procedure(s)

Diagnosis 1:	ICD 10 Code 1:
Diagnosis 2:	ICD 10 Code 2:
Diagnosis 3:	ICD 10 Code 3:
Requested Exam / CPT Code(s):	
CPT Code(s) Description:	

Clinical History

Did you include the following information with the pre-auth request packet? Office Visit Notes ☐Y ☐N Prior Imaging ☐Y ☐N

Labs ☐Y ☐N Op Reports ☐Y ☐N Medications for current problem ☐Y ☐N PT/OT Notes ☐Y ☐N

FAX THIS FORM, PTS INS CARD AND CLINICAL HISTORY TO 877-211-9603

Failure to provide relevant records may delay the determination process