SJRA South Jersey Radiology Associates

PRE-AUTHORIZATION REQUEST FORM

CALL: (888) 909-7572

FAX: (856) 983-1582

Please fax this completed form along with medical records, imaging tests, and order for exam.

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

Patient Information

First Name:	Middle Initial:	Last Name:
DOB (MM/DD/YYYY):		Gender: ☐ Male ☐ Female
Address:		Apartment #:
City:	State:	Zip Code:
Patient Phone #:		Patient Email Address:
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 #:		Provider Fax #:
Address:		Suite #:
City:	State	Zip Code:
Office Contact:		Extension:

Diagnosis & 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-authorization request packet?	
Office Visit Notes: ☐ Yes ☐ No	Prior Imaging: ☐ Yes ☐ No
Labs: ☐ Yes ☐ No	Op Reports: ☐ Yes ☐ No
Medications for Current Problem: ☐ Yes ☐ No	PT/OT Notes: ☐ Yes ☐ No

FAX THIS FORM, PATIENT'S INSURANCE CARD, AND CLINICAL HISTORY TO (856) 983-1582

Failure to provide relevant records may delay the determination process.