

## 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.

First Name:	Patient Information				
Address:	First Name:	Middle Initial:	Last Name:		
State   Zip Code	DOB (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
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 8: 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 No Labs: Yes No	Address:		Apartment #:		
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: 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	City:	State:	Zip Code:		
Member ID:   Group ID:	Patient Phone #:		Patient Email Address:		
COPY OF INSURANCE CARD REQUIRED (FRONT & BACK)  COPY OF PRESCRIPTION/ELECTRONIC ORDER REQUIRED  Ordering Provider  First Name:  Primary Specialty:  TIN #:  Individual NPI #:  Provider Fax #:  Address:  Suite #:  City:  State  Zip Code:  Office Contact:  Extension:  Diagnosis & Procedure(s)  Diagnosis 3:  ICD 10 Code 1:  Diagnosis 3:  ICD 10 Code 2:  Diagnosis 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  Op Reports: Yes No	Health Insurance Plan:				
Ordering Provider  First Name:	Member ID:		Group ID:		
Ordering Provider  First Name:	COPY OF INSURANCE CARD REQUIRED (FRONT & BACK)				
First Name:  Primary Specialty:  Provider Phone #:  Address:  City:  Office Contact:  Diagnosis & Procedure(s)  Diagnosis 2:  Diagnosis 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  Prior Imaging:  Yes  No	COPY OF PRESCRIPTION/ELECTR	RONIC ORDER REQ	UIRED		
First Name:  Primary Specialty:  Provider Phone #:  Address:  City:  Office Contact:  Diagnosis & Procedure(s)  Diagnosis 1:  Diagnosis 2:  Diagnosis 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  Prior Imaging:  Yes  No	Ordering Brevider				
Primary Specialty:			T		
Provider Phone #:  Address:  Suite #:  City:  Office Contact:  Diagnosis & Procedure(s)  Diagnosis 1:  Diagnosis 2:  Diagnosis 3:  ICD 10 Code 1:  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:		1			
Address:  City:  State  Zip Code:  Office Contact:  Extension:  Diagnosis & Procedure(s)  Diagnosis 1:  Diagnosis 2:  Diagnosis 3:  ICD 10 Code 1:  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:		TIN #:			
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		_			
Office Contact:  Extension:  Diagnosis & Procedure(s)  Diagnosis 1:  Diagnosis 2:  Diagnosis 3:  ICD 10 Code 2:  Diagnosis 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:	Address:		Suite #:		
Diagnosis & Procedure(s)  Diagnosis 1:	City:	State	Zip Code:		
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	Office Contact:		Extension:		
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	Diagnosis & Brosoduro(s)				
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:					
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:	-				
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:					
CPT Code(s) Description:  Clinical History  Did you include the following information with the pre-authorization request packet?  Office Visit Notes:			ICD 10 Code 3:		
Clinical History  Did you include the following information with the pre-authorization request packet?  Office Visit Notes:					
Did you include the following information with the pre-authorization request packet?  Office Visit Notes:	CPT Code(s) Description:				
Office Visit Notes:	Clinical History				
Labs:	Did you include the following infor	mation with the pre	e-authorization request packet?		
	Office Visit Notes:		Prior Imaging:		
Medications for Current Problem: ☐ Yes ☐ No ☐ PT/OT Notes: ☐ Yes ☐ No	Labs: 🗌 Yes 🗌 No		Op Reports:		
11/01/10000	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.