

## Prior Authorization Request



## **\*\*Chart Notes Required\*\***

 $Please \ fax \ to: \ 503 \cdot 574 \cdot 6464 \ or \ 800 \cdot 989 \cdot 7479 \ | \ Questions \ please \ call: \ 503 \cdot 574 \cdot 6400 \ or \ 800 \cdot 638 \cdot 0449 \ respectively \ (1.5)$ 

For High Tech Imaging	American Imaging Management (AIM)   Phone: 800-920-1250   <u>http://www.americanimaging.net/goweb/</u>   For Registration <u>:</u> Providence PIN #: 045-83169		
Member Information			
Last Name:		First Name:	
Insurance ID #:		DOB:	
Address:		Date of Service:	Date Span Requested:
Primary Care Physician (PCP):			
Requesting Provide	er:		TIN#:
Address:			NPI#:
Servicing Provider	:		TIN#:
Address:			NPI#:
Servicing Facility:			TIN#:
Address:			NPI#:
Requested Item/Service:			
ICD-10 Code(s): CPT Code(s):			
10D-10 000e(s).			
Requested Services:			
□ Office Visits, # of visits: □ Surgery   □ Diagnostic   □ Facility Auth Only   □ DME   Other			
Type of Service:			
<ul> <li>□ Elective Inpatient Admit   □ Elective Outpatient Surgery   □ Office Surgery   □ Outpatient Diagnostics   □ ASC</li> <li><u>Expedite</u>- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. Request must include supporting documentation to substantiate an expedited review.</li> <li>Explanation Required:</li> </ul>			
In-Network Benefits: Request must include supporting documentation to substantiate why services cannot be provided by an in- network provider/facility.  New Patient Established Patient   Date last seen Explanation Required:			
**REQUIRED** Contact Information:			
Name:		Phone #:	Fax#:

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