



# Prior Authorization Request



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

Please fax to: 503-574-6464 or 800-989-7479 | Questions please call: 503-574-6400 or 800-638-0449

For High Tech Imaging	American Imaging Management (AIM)   Phone: 800-920-1250   <a href="http://www.americanimaging.net/goweb/">http://www.americanimaging.net/goweb/</a>   For Registration: Providence PIN #: 045-83169	
Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:	Date of Service:	Date Span Requested:
<b>Primary Care Physician (PCP):</b>		
<b>Requesting Provider:</b>		TIN#:
Address:		NPI#:
<b>Servicing Provider:</b>		TIN#:
Address:		NPI#:
<b>Servicing Facility:</b>		TIN#:
Address:		NPI#:
<b>Requested Item/Service:</b>		
ICD-10 Code(s):		CPT Code(s):
<b>Requested Services:</b> <input type="checkbox"/> Office Visits, # of visits: _____ <input type="checkbox"/> Surgery   <input type="checkbox"/> Diagnostic   <input type="checkbox"/> Facility Auth Only   <input type="checkbox"/> DME   Other _____		
<b>Type of Service:</b> <input type="checkbox"/> Elective Inpatient Admit   <input type="checkbox"/> Elective Outpatient Surgery   <input type="checkbox"/> Office Surgery   <input type="checkbox"/> Outpatient Diagnostics   <input type="checkbox"/> ASC		
<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. <b>Request must include supporting documentation to substantiate an expedited review.</b> Explanation Required:		
<u>In-Network Benefits</u> : <b>Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility.</b> <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient   Date last seen _____ Explanation Required:		
<b>**REQUIRED** Contact Information:</b>		
Name:	Phone #:	Fax#:

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