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 | http://www.americanimaging.net/goweb/ | For Registration: 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 Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:
Servicing Facility:	TIN#:
Address:	NPI#:

Requested Item/Service:	
ICD-10 Code(s):	CPT Code(s):

Requested Services:

☐ Office Visits, # of visits: _____ ☐ Surgery | ☐ Diagnostic | ☐ Facility Auth Only | ☐ DME | Other _____

Type of Service:

☐ Elective Inpatient Admit | ☐ Elective Outpatient Surgery | ☐ Office Surgery | ☐ Outpatient Diagnostics | ☐ ASC

Expedite- 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.**

Explanation Required:

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#:

 3/23/20