

## \*\*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	Carelon Medical Benefits Management   Phone: 800-920-1250   <a href="http://carelon.com">http://carelon.com</a>   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#:
Type of Care:		
<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		
ICD-10 Code(s):	CPT Code(s):	Requested Item/Service:
<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 _____		
Comments		
In-Network Benefits: <b style="color: red;">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: _____		
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 time frame. <b style="color: red;">Request must include supporting documentation to substantiate an expedited review.</b> Explanation Required: _____		
**REQUIRED** Contact Information:		
Name:	Phone:	Fax: