

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: <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 _____			
Type of Service: <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 style="color: red;">Request must include supporting documentation to substantiate an expedited review. Explanation Required:			
<u>In-Network Benefits</u> : <b style="color: red;">Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient Date last seen _____ Explanation Required:			
REQUIRED Contact Information:			
Name:		Phone #:	Fax#: