

Chart Notes Required

Please fax this request to: 503-574-6464 or 800-989-7479

Please call our PA department if you have any questions at: 503-574-6400 or 800-638-0449

For High Tech Imaging	American Imaging Management (AIM) Radiology Prior Authorization Phone: 800-920-1250 For Online Requests: http://www.americanimaging.net/goweb/ For Registration: Providence PIN #: 045-83169	
Member Information		
Last Name:	First Name:	
ID #:	DOB:	
Address:		
Provider Information		
Primary Care Physician (PCP):		
Requesting Provider:	TIN#:	
Address:	NPI#:	
Servicing Provider:	TIN#:	
Address:	NPI#:	
Servicing Facility:	TIN#:	
Address:	NPI#:	
Request Information		
ICD-10 Code(s):		
CPT Code(s):		
Transplant Services:		
<input type="checkbox"/> HLA Typing Related: Y or N Relationship: _____ Name: _____ DOB: _____ <input type="checkbox"/> Comprehensive Transplant Evaluation (Includes labs not on PA list) If living donor for solid organ transplant, include name of potential donor: _____ <input type="checkbox"/> Bone Marrow Biopsy (Includes proc and cytology codes) <input type="checkbox"/> Transplant <input type="checkbox"/> Annual Post-Transplant Follow-up <input type="checkbox"/> Wait List Management <input type="checkbox"/> Transplant Center Referral <input type="checkbox"/> Initial Post-Transplant Follow-up <input type="checkbox"/> Type of Transplant being considered: _____		
DOS:	Date Span Requested:	
Comments:		
REQUIRED Contact Information:		
Name:	Phone #:	
Fax #:	Total # of pages faxed, including cover page:	
<input type="checkbox"/> PLEASE EXPEDITE! The provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy (CMS definition)		