

## \*\*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			
<p><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.</b></p> <p>Explanation Required:</p>			
<p><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.</b> <input type="checkbox"/> New Patient         <input type="checkbox"/> Established Patient   Date last seen _____</p> <p>Explanation Required:</p>			
**REQUIRED** Contact Information:			
Name:		Phone #:	Fax#: