CARE to CARE
MULTI-SPECIALTY MANAGEMENT

# Imaging Excellence Program

Authorization Request Form

Fax this request form to 1-888-248-4884

(Please print clearly)

STOP **Please consider using the web to submit your requests. To submit online, visit: https://caretocare.careportal.com.**

****If Urgent Please Call**

| **Referring Provider Information** | | | |
|---|---|---|---|
| **#1 Date request submitted:** | MM/DD/YYYY | **#2 Office contact person:** | |
| **#3 Provider Name:** | | **#4 Physician Specialty:** | |
| **#5 Physician ID (NPI):** | | **#6 Phone:** (XXX) XXX - XXXX | **#7 Fax:** (XXX) XXX - XXXX |
| **#8 E-mail Address:** | | | |

| **Rendering Facility/Practice Information** | | | |
|---|---|---|---|
| **#9 Facility/Practice Name:** | | **#10 Facility/Practice Address:** | |
| **#11 Phone:** (XXX) XXX - XXXX | **#12 Fax:** (XXX) XXX - XXXX | **#13 Facility/Practice NPI#:** | |

| | | | |
|---|---|---|---|
| **#14 Member name:** | | **#15 Date of Birth:** | MM/DD/YYYY |
| **#16 Member ID#:** | | **#17 Member Phone #:** | (XXX) XXX - XXXX |

**List procedure(s) Ordered**

| #18 Procedures | #19 CPT code | #20 Modifier | #21 Units |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| **#22 Clinical indications for the ordered exams (e.g., signs, symptoms with severity and duration, working diagnosis)** | |
|---|---|
| THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY OF MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED. | **#23 Primary ICD-10 Code** |
| | |
| | |
| | |

**Any relevant prior tests, treatments or other information**

| | | | | | |
|---|---|---|---|---|---|
| **#24 Days** (circle): | M T W Th F | **#25 Times:** | | **#26 Phone:** | (XXX) XXX - XXXX |
| **#27 Requested by (print):** | | | | **#28 Submission Date:** | MM/DD/YYYY |

**#29 Referring Provider Signature:**



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## Instructions for Filling out Form Fields of Required Information

| Field No. | Name | **Description** – Below contains a brief description. For more detailed information see Provider Manual. |
|---|---|---|
| **1.** | *Date Request Submitted* | Date the Request form is being submitted **–** MM/DD/YYYY |
| **2.** | *Office Contact Person* | Person filling Prior Authorization Request Form or Name of Best Contact Person |
| **3.** | *Provider Name* | Referring/Ordering Provider's First & Last Name |
| **4.** | *Physician Specialty* | Referring/Ordering Provider's Specialty |
| **5.** | *Physician ID (NPI)* | Referring/Ordering Provider's NPI # - Mandatory |
| **6.** | *Phone* | Referring/Ordering Provider's Office Phone # - 1 (XXX) XXX-XXXX |
| **7.** | *Fax* | Referring/Ordering Provider's Office Fax # - 1 (XXX) XXX-XXXX |
| **8.** | *E-Mail Address* | Referring/Ordering Provider's Office E-Mail Address - Mandatory |
| **9.** | *Facility/Practice Name* | Rendering Facility/Practice Name Where Procedure Will Take Place |
| **10.** | *Facility/Practice Address* | Rendering Facility/Practice Address Where Procedure Will Take Place |
| **11.** | *Phone* | Rendering Facility/Practice Phone # - 1 (XXX) XXX-XXXX |
| **12.** | *Fax* | Rendering Facility/Practice Fax # - 1 (XXX) XXX-XXXX |
| **13.** | *Facility/Practice NPI #* | Insert Rendering Facility/Practice NPI# |
| **14.** | *Member Name* | Name of Member Procedure is Being Requested For |
| **15.** | *Date of Birth* | Date of Birth for the Member **–** MM/DD/YYYY |
| **16.** | *Member ID #* | Medicaid ID # of the Member |
| **17.** | *Member Phone #* | Best Contact Phone # for the Member - 1 (XXX) XXX-XXXX |
| **18.** | *Procedures* | Description or Modality of Procedure(s) Being Requested |
| **19.** | *CPT Code* | CPT Code Associated with Requested Procedure(s) |
| **20.** | *Modifier* | Body Modifier (i.e. Left, Right) |
| **21.** | *Units* | Number of Requested Units |
| **22.** | *Clinical Indications for the Ordered Exams* | Explained in Description, Option to Fill In Information Fields or Attach Clinical Notes |
| **23.** | *Primary ICD-9 Code* | Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code |
| **24.** | *Days (Circle)* | Best Day(s) Available to Reach Referring Physician **–** circle days |
| **25.** | *Times* | Best Time(s) of Day to Reach Referring Physician **–** (Note Program Open 8am-7pm EST) |
| **26.** | *Phone* | Best Phone # to Reach Referring Physician - 1 (XXX) XXX-XXXX |
| **27.** | *Requested by (Print)* | Printed Name of Referring/Ordering Provider |
| **28.** | *Submission Date* | Date the Prior Authorization Form is Being Submitted |
| **29.** | *Signature* | Signature of Ordering Provider |

Revised 01/2017

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