Advanced Imaging Prior Authorization Request Form

Fax this request form to 1-888-931-2468.
(Please print clearly)

****If Urgent Please Call** **Date request received:** _____

Referring Provider Information

#1 Date request submitted:	M M / D D / Y Y Y Y	#2 Office contact person:	
#3 Provider Name:		#4 Physician Medicaid (CMAP) ID #:	
#5 Provider ID (NPI):		#6 Phone: (XXX) XXX - XXXX	#7 Fax: (XXX) XXX - XXXX

Rendering Facility/Practice Information

#8 Facility/Practice Name:		#9 Facility/Practice Address:	
#10 Phone: (XXX) XXX - XXXX	#11 Fax: (XXX) XXX - XXXX	#12 Facility/Practice Medicaid (CMAP) ID #:	

#13 Member name:		#14 Date of Birth:	M M / D D / Y Y Y Y
#15 Medicaid ID#:		#16 Member Phone #:	(XXX) XXX - XXXX
#17 Program: (check one)	Husky: ☐A ☐B ☐C ☐D or ☐ Limited Benefits Group ☐Charter Oak		

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-9 Code

Any relevant prior tests, treatments or other information

If our Physician Reviewer needs to contact the ordering provider, what is the best day, time and phone number?

#24 Days (circle):	M T W Th F	#25 Times:		#26 Phone:	(XXX) XXX - XXXX
#27 Requested by (print):				#28 Submission Date:	M M / D D / Y Y Y Y

#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 Auth Form or Name of Best Contact Person
3.	*Provider Name*	Referring/Ordering Provider's **First & Last Name**
4.	*Physician Medicaid (CMAP) ID #*	Insert Referring/Ordering Provider's Medicaid (CMAP/AVRS) ID – **Mandatory**
5.	*Provider 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.	*Facility/Practice Name*	Rendering Facility/Practice Name Where Procedure Will Take Place
9.	*Facility/Practice Address*	Rendering Facility/Practice Address Where Procedure Will Take Place
10.	*Phone*	Rendering Facility/Practice Phone # **- 1 (XXX) XXX-XXXX**
11.	*Fax*	Rendering Facility/Practice Fax # **- 1 (XXX) XXX-XXXX**
12.	*Facility/Practice Medicaid (CMAP) ID #*	Insert Rendering Facility/Practice Medicaid (CMAP/AVRS) ID – **Optional, Provide if available**
13.	*Member Name*	Name of Member Procedure is Being Requested For
14.	*Date of Birth*	Date of Birth for the Member **– MM/DD/YYYY**
15.	*Medicaid ID #*	Medicaid ID # of the Member
16.	*Member Phone #*	Best Contact Phone # for the Member **- 1 (XXX) XXX-XXXX**
17.	*Program: (check one)*	Program under which Member is covered **(Please select ONE box)**
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-9 Code Required with Each Requested CPT Code
24.	*Days (Circle)*	Best Day(s) Available for Reaching Office Contact **– circle days**
25.	*Times*	Best Time(s) of Day for Reaching Office Contact **– (Note Call Center is Open 8am-7pm)**
26.	*Phone*	Best Phone # for Reaching Office Contact **- 1 (XXX) XXX-XXXX**
27.	*Requested by (Print)*	Printed Name of Referring/Ordering Physician
28.	*Submission Date*	Date the Prior Authorization Form is Being Submitted (Same as #1) **– MM/DD/YYYY**
29.	*Referring Provider Signature*	Signature of Referring/Ordering Physician