Prior Authorization Request Form

Fax this request form to
1199SEIU Benefit Funds Radiology Review at
(877) 601-1199
(Please print clearly)

Care to Care

Date request received: _____/_____/_____

Date request submitted:		**Office contact person:**	
Referring physician (First/Last name):		**Physician specialty:**	
Physician phone #:	( ) -	**Physician fax:**	( ) -
Facility and location for procedure:			☐ **MVA (No Fault)**
Patient's name:		**Date of birth:**	_____/_____/_____
Health plan/group name:	**1199SEIU**	**Patient phone #:**	( ) -
Member ID#:		**State:**	

List procedure(s) ordered

Procedures	CPT code if available

Clinical indications (e.g., signs, symptoms with severity and duration, working diagnosis) for the ordered exams

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.	**ICD-9 (Required)**

Any relevant prior tests, treatments or other information

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

Days (circle)**:**	S M T W Th F S	**Times:**		**Phone:**	( ) -
Requested by (print):				**Submission date:**	_____/_____/_____

Signature:

Rev. 12-2010