



Prior Authorization Request Form

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



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:			<input type="checkbox"/> 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:

This fax contains privileged and confidential information intended only for the use of the specific individual or entity named above. If you or your employer is not the intended recipient of this facsimile (or agent responsible for delivering it to the intended recipient), you are hereby notified that any unauthorized distribution or copying of this facsimile or the information contained in it is strictly prohibited. If you have received this facsimile in error, please notify the person named above by phone and return the original facsimile to the above address via the U.S. Postal Service.