Radiology Services Pre-Authorization Form

Please complete all applicable fields to facilitate pre-authorization for radiology services. Attach supporting documentation as required by payer guidelines.

Patient Information

Patient Name: _____
Date of Birth: ____/____/_____
Patient ID/Insurance #: _____
Phone Number: _____
Address: _____

Ordering Provider Information

Provider Name: _____
NPI/Lic#: _____
Practice Name: _____
Phone/Fax: _____

Insurance Information

Insurance Company: _____
Policy/Group #: _____
Pre-Auth Phone #: _____

Requested Radiology Service(s)

Service Type	Body Part	CPT/Procedure Code	Reason/Diagnosis (ICD-10)	Clinical Justification
_____	_____	_____	_____	_____

Service type examples: MRI, CT Scan, Ultrasound, X-Ray, Mammogram, etc.

Previous Imaging/Relevant History

Prior Studies (Y/N): _____
Date and Facility: _____
Results/Findings: _____

Provider Signature

Provider Signature: _____
Date: ____/____/_____

☐ I have attached all supporting clinical documentation.

Instructions: Fax or upload this completed form and documentation to the patient's insurance company as per their pre-authorization process.
Keep a copy for your records.