ami Atlantic Medical Imaging

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Galloway, New Jersey 08205
Phone: 855-677-9729
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AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION

Patient First Name:_____ Patient Last Name:_____

DOB: _____ / _____ / _____ Gender (Circle): M F

Insurance Company Name: _____

Policy ID #_____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____

Fax #: _____

INS Provider / Tax ID#:_____

Diagnosis 1: _____ ICD10 Code 1:_____

Diagnosis 2:_____ ICD10 Code 2: _____

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): (MANDATORY)

_____

_____

Findings from prior radiology exams: _____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

EXAM TYPE: ❑ MRI ❑ MRA
❑ With & Without Contrast ❑ Without Contrast
❑ With Contrast

❑ Abdomen
❑ Brachial Plexus
❑ Brain
Hormone Levels
_____
❑ Breast, Bilateral
❑ Breast, Bilateral Implant Evaluation
❑ Breast, Bilateral Cancer Evaluation
❑ Chest
❑ MRCP
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
_____
Type of antibiotics
_____
Duration of antibiotics
_____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Ankle Rt ___ LT ___
❑ Elbow Rt ___ LT ___
❑ Foot Rt ___ LT ___
❑ Hand Rt ___ LT ___
❑ Hip Rt ___ LT ___
❑ Knee Rt ___ LT ___
❑ Shoulder Rt ___ LT ___
❑ Wrist Rt ___ LT ___
❑ Other CPT Code: _____

EXAM TYPE: ❑ CT ❑ CTA
❑ With & Without Contrast ❑ Without Contrast
❑ With Contrast

❑ Abdomen
❑ Abdomen/Pelvis
❑ Brain
❑ Carotid
❑ Chest
❑ Coronary CTA
❑ Head
❑ Heart
❑ Kidney
❑ Urography
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
_____
Type of antibiotics
_____
Duration of antibiotics
_____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Upper Extremity _____
❑ Lower Extremity _____
Date of Injury: ____ / ____ /____
Date of onset of symptoms: ____ / ____ /____
Date of PT start: ____ / ____ /____
Medications: _____
❑ Other _____ CPT Code:_____
❑ With 3D Recons

❑ Please notify me _____ days before authorization expiration.

Submitted by: _____ Phone #: _____ Date: _____ / _____ / _____

4 Fax completed forms to: 855-677-9783