Atlantic Medical Imaging
72 West Jimmie Leeds Road, Suite 1100
Galloway, New Jersey 08205
Phone: 855-677-9729
Fax: 855-677-9783

Authorization Request Designation Form

[Ordering Physician] designates Atlantic Medical Imaging (AMI) to submit clinical authorization requests on his/her behalf. [Ordering Physician] agrees that when requesting that AMI submit a clinical authorization request for a patient, [Ordering Physician] shall furnish AMI complete and accurate documentation of the patient's diagnosis, clinical condition, test results, and treatment history in order to demonstrate medical necessity.

No Assurance of Authorization Approval
[Ordering Physician] understands that AMI makes no representation to [Ordering Physician] or assurances that the designation of AMI to submit clinical authorization requests hereunder shall result in approval of any preauthorization request. AMI shall have no liability to [Ordering Physician] or any patient for any failure to obtain an authorization.

Transparency of Call Center; Provision of Medical Record Documentation
[Ordering Physician] shall not provide AMI with its website login and password credentials. [Ordering Physician] understands that AMI representatives will identify themselves as representatives of AMI and will disclose the nature of the clinical authorization program. AMI will use its own login and password credentials when submitting [Ordering Physician's] clinical authorization requests via the Internet. For clinical authorization requests, [Ordering Physician] agrees to provide copies of patient information and medical records to AMI upon request and at no charge. [Ordering Physician] agrees to provide any reasonable documentation to AMI or the patient's health plan that may be required for an appeal of an adverse authorization decision.

Accurate Information; Compliance
[Ordering Physician] understands and acknowledges that any person furnishing materially false or misleading information to AMI in connection with a clinical authorization request may be subject to civil liability and/or criminal penalties and that in such event AMI may terminate, suspend or otherwise limit [Ordering Physician's] rights under this designation and advise the health plan of such action for its information and action. [Ordering Physician] shall comply with the Health Insurance Portability and Accountability Act of 1996, as amended [HIPAA] with respect to the transfer of patient information to, and maintenance of patient information by AMI.

By signing this designation, you will be agreeing to the above terms and conditions of the foregoing Designation Agreement. In so doing, you attest that you are the physician identified below OR that you are authorized to execute the foregoing Agreement on behalf of the Group identified below and that the Group is authorized to execute the foregoing Agreements on behalf of the physicians that are billed under the Group's TIN.

Physician Last Name: _____ First Name: _____ Middle Initial: ____

OR Group Name: _____

TIN: _____ Individual NPI: _____ or Organization NPI: _____

Address: _____

_____

Telephone: _____

Email: _____

Office Contact: _____

Date: ____ /____ /____

Preferred Method of Contact

❑ Fax: _____

❑ Secure Email

Fax completed forms to: (609) 653-8764