



72 West Jimmie Leeds Road, Suite 1100
 Galloway, New Jersey 08205
 Phone: 855-677-9729
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ONCOLOGY AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION (PLEASE INCLUDE PATIENT DEMO SHEET, IF AVAILABLE)

Patient Name: _____ DOB: ____ / ____ / ____ Gender (Circle): M F
 Address: _____
 City: _____ State: _____ Zip Code: _____ Phone: ____ - ____ - ____
 Insurance Company Name: _____ Policy ID #: _____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____
 Fax #: _____
 INS Provider / Tax ID#: _____
 Reason for Exam: _____
 Diagnosis, Staging, Re-staging, Suspected Recurrence, Surveillance

Diagnosis 1: _____ ICD10 Code 1: _____
 Diagnosis 2: _____ ICD10 Code 2: _____
 For new cancer diagnosis, please include type of cancer and date of diagnosis: _____

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

Findings from prior radiology exams: _____
 Tissue diagnosis: Yes No
 Rising Tumor Markers: Yes No If yes, please indicate which one(s) and value(s) _____
 Chemotherapy (Start Date): ____ / ____ / ____ Chemotherapy (End Date): ____ / ____ / ____
 Radiation (Start Date): ____ / ____ / ____ Radiation (End Date): ____ / ____ / ____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

- | | | |
|--|---|--|
| <input type="checkbox"/> PET/CT

<input type="checkbox"/> Brain
<input type="checkbox"/> Cardiac
<input type="checkbox"/> Oncology (Skull - Mid Thigh)
Type of Cancer _____
<input type="checkbox"/> Melanoma (whole body)
<input type="checkbox"/> Other _____
CPT Code: _____

Isotope agent:
<input type="checkbox"/> FDG <input type="checkbox"/> NaF | <input type="checkbox"/> CT

<input type="checkbox"/> With & Without Contrast
<input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast

<input type="checkbox"/> Abdomen
<input type="checkbox"/> Chest, Thorax
<input type="checkbox"/> Head
<input type="checkbox"/> Neck
<input type="checkbox"/> Pelvis
<input type="checkbox"/> Other _____
CPT Code: _____ | <input type="checkbox"/> MRI

<input type="checkbox"/> With & Without Contrast
<input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast

<input type="checkbox"/> Abdomen <input type="checkbox"/> Neck
<input type="checkbox"/> Brain <input type="checkbox"/> Pelvis
<input type="checkbox"/> Breast, Bilateral
<input type="checkbox"/> Chest, Thorax
<input type="checkbox"/> Head
<input type="checkbox"/> Other _____
CPT Code: _____ |
|--|---|--|

Please notify me _____ days before authorization expiration.
 Submitted by: _____ Phone #: _____ Date: ____ / ____ / ____

4 Fax completed forms to: 855-677-9783