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

NUCLEAR MEDICINE 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#:_____

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)

PET/CT

- ❑ Brain
- ❑ Cardiac
- ❑ Oncology (Skull - Mid Thigh)
  Type of Cancer_____
- ❑ Melanoma (whole body)
- ❑ Other _____
  CPT Code: _____

Isotope agent:
❑ FDG ❑ NaF

NUCLEAR MEDICINE

- ❑ Biliary Ejection Fraction
- ❑ Biliary Scan
- ❑ Bone Scan 3 Phase
- ❑ Bone Scan Limited
- ❑ Bone Scan Total
- ❑ Gallium Scan
- ❑ Gastric Emptying Scan
  ❑ Liquid ❑ Solid
- ❑ Hepatobiliary Scan
- ❑ Hepatobiliary Scan with Ejection Fraction
- ❑ Liver/Spleen Scan
- ❑ Gated (MUGA/Cardiac Blood Pool)
- ❑ Parathyroid Scan
- ❑ Other _____
  CPT Code: _____

- ❑ Renal Pharmacological Intervention
  ❑ Lasix ❑ Captopril
- ❑ Salivary Gland Function
- ❑ Thyroid Uptake and Scan

- ❑ SPECT Bone
- ❑ SPECT Brain
- ❑ SPECT Liver
- ❑ SPECT Liver for Hemangioma
- ❑ SPECT Tumor Localization

❑ Please notify me _____ days before authorization expiration.

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

4 Fax completed forms to: 855-677-9783