

CT/CTA/MRI/MRA PRIOR AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS			
Patient Name (First, Last):		DOB:	
Health Plan:	Member ID:	Group #:	
SECTION 2. ORDERING PROVIDER INFORMATION			
Physician Name (First, Last):			
Primary Specialty:	NPI:	Tax ID:	
Phone #:	Fax #:	Contact Name:	
SECTION 3. FACILITY INFORMATION			
Facility Name:		Facility Tax ID:	NPI:
Address:	City:	State:	Zip:
Phone #:	Fax #:	Date of Service:	
SECTION 4. EXAM REQUEST			
<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> CTA <input type="checkbox"/> MRA			
CPT Code(s):			
Description:			
ICD Diagnosis Code(s):			
Description:			
Date of first office visit for this condition with any provider:			
Date of most recent office visit for this condition with any provider:			
SECTION 5. SELECT APPLICABLE BODY REGION AND CHECK REASON(S) FOR STUDY (CHECK ALL THAT APPLY)			
<input type="checkbox"/> ABDOMINAL/ PELVIS			
Abd/Pelvis Combination Study <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Acute Pain (less than 48 hrs) <input type="checkbox"/> Hematuria <input type="checkbox"/> Inflammatory Bowel Disease consistent with Appendicitis, Diverticulitis, or Abscess <input type="checkbox"/> Suspected Hemochromatosis <input type="checkbox"/> Abdominal or Pelvic Mass <input type="checkbox"/> Suspected Vascular Disease, Mesenteric Ischemia <input type="checkbox"/> Suspected Renal Artery Stenosis <input type="checkbox"/> Hernia <input type="checkbox"/> Pancreatic or adrenal mass seen on other imaging	<input type="checkbox"/> Chronic Pain (more than 48 hours) <input type="checkbox"/> Abdominal/Pelvic Trauma <input type="checkbox"/> Anemia <input type="checkbox"/> Fever of Unknown Origin [FUO] <input type="checkbox"/> Ascites <input type="checkbox"/> Prostate Neoplasm <input type="checkbox"/> Pre- or post-OP evaluation <input type="checkbox"/> Lower extremity edema <input type="checkbox"/> Significant weight loss (10% of body weight over 6 months or less) <input type="checkbox"/> Transplant	<input type="checkbox"/> Kidney/Urethral Obstruction or Calculus <input type="checkbox"/> Jaundice, Abnormal Liver Function Tests <input type="checkbox"/> Endometrial Abnormality <input type="checkbox"/> Staging (malignancy) <input type="checkbox"/> Suspected Aneurysm/Dissection/AVM <input type="checkbox"/> MRCP <input type="checkbox"/> Lower extremity claudication <input type="checkbox"/> Suspected abnormality of pelvic bones or muscular structures <input type="checkbox"/> Pelvic Floor Dysfunction <input type="checkbox"/> Other (describe): _____	
<input type="checkbox"/> SPINE			
<input type="checkbox"/> Neurological Deficits <input type="checkbox"/> Known or suspected infection <input type="checkbox"/> Persistent Pain <input type="checkbox"/> Radiculopathy <input type="checkbox"/> Possible Fracture <input type="checkbox"/> Other (describe): _____	<input type="checkbox"/> Trauma or recent injury <input type="checkbox"/> Known or suspected tumor on bone scan or x-ray <input type="checkbox"/> Unilateral Muscle wasting <input type="checkbox"/> Pre- or post-OP Evaluation <input type="checkbox"/> Suspected Multiple Sclerosis (not applicable for CT or for CT or MRI of lumbar region)		
PRIOR /CURRENT TREATMENT(S)			
Check One (Prior Treatment)		Check all treatments that apply	
<input type="checkbox"/> No Prior Treatment <input type="checkbox"/> 3–5 weeks of treatment <input type="checkbox"/> 6 or more weeks of treatment	<input type="checkbox"/> NSAIDS <input type="checkbox"/> Spine Injections <input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Oral Steroid	
<input type="checkbox"/> BREAST MRI DIAGNOSTIC <input type="checkbox"/> BREAST MRI SCREENING			
<input type="checkbox"/> Abnormal/inconclusive mammogram or ultrasound <input type="checkbox"/> Suspected Recurrence of Breast Cancer <input type="checkbox"/> Mass evaluation post-surgery	<input type="checkbox"/> Evaluate extent of invasive cancer <input type="checkbox"/> Evaluation axillary node metastasis <input type="checkbox"/> Dense breast tissue	<input type="checkbox"/> Evaluation of symptomatic patients with breast implants, for detection of implant rupture <input type="checkbox"/> Positive Margins Post-OP <input type="checkbox"/> 6 months follow up abnormal MRI (birads3)	

<input type="checkbox"/> REQUEST FOR ANNUAL SCREENING FOR BREAST CANCER (If yes, check reason(s) below)		
<input type="checkbox"/> Lifetime risk 20% or greater as defined by BRACA PRO or other models	<input type="checkbox"/> History of lobular or ductal carcinoma in situ on biopsy	<input type="checkbox"/> Radiation therapy to chest between ages 10–30
<input type="checkbox"/> BRCA1 and BRCA2 mutation	<input type="checkbox"/> Li-Fraumeni Syndrome, Cowden Syndrome	<input type="checkbox"/> Bannayan-Riley-Ruvucaba Syndrome
<input type="checkbox"/> BRAIN/HEAD		
<input type="checkbox"/> Known or suspected tumor/mass or metastasis	<input type="checkbox"/> New onset of seizures	<input type="checkbox"/> Breakthrough seizures
<input type="checkbox"/> Recent significant head trauma	<input type="checkbox"/> Pre- or post-OP evaluation	<input type="checkbox"/> Vascular abnormalities (AVM Aneurysm Dissection Stenosis, Obstruction)
<input type="checkbox"/> Known or suspected stroke	<input type="checkbox"/> Suspected Multiple Sclerosis (not for CT)	<input type="checkbox"/> Suspected acoustic neuroma
<input type="checkbox"/> Brain infection or abscess	<input type="checkbox"/> Follow up treatment (surgery/chemotherapy/radiation)	<input type="checkbox"/> Suspected pituitary adenoma and elevated prolactin (>20 ng/ml)
<input type="checkbox"/> Abnormal neurological exam		
New Headache: <input type="checkbox"/> With fever <input type="checkbox"/> With exertion <input type="checkbox"/> On awakening <input type="checkbox"/> Focal neurological findings <input type="checkbox"/> Worst headache of life (thunderclap)		
Chronic Headache: <input type="checkbox"/> New neurological findings <input type="checkbox"/> New syncope <input type="checkbox"/> New mental status changes		
<input type="checkbox"/> CHEST		
<input type="checkbox"/> Chest wall or pleural mass	<input type="checkbox"/> Suspected vascular abnormality, aneurysm, AVM, congenital anomaly	<input type="checkbox"/> Pre- or post-OP evaluation
<input type="checkbox"/> Follow up trauma	<input type="checkbox"/> Suspected Pulmonary Embolus	<input type="checkbox"/> Mediastinal mass
<input type="checkbox"/> Significant Hemoptysis	<input type="checkbox"/> Persistent infiltrate/pneumonia despite 4–6 weeks antibiotic therapy	<input type="checkbox"/> Screening for lung nodules
<input type="checkbox"/> Persistent unexplained wheeze	<input type="checkbox"/> Suspected/known asbestosis or other pneumoconiosis	<input type="checkbox"/> Lung abscess or inflammatory process
<input type="checkbox"/> Lesion on chest x-ray suggestive of malignancy or metastatic disease	Chest x-ray results:	<input type="checkbox"/> Chest x-ray or PFT suggestive of pulmonary fibrosis
<input type="checkbox"/> Standard staging or post therapy follow-up for patient with a pathologically proven malignancy	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Signs or symptom suggestive of lung cancer (unintentional weight loss, anemia, paraneoplastic syndrome, etc.)
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Not performed in past 2 months	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Acquired Pediatric Heart Disease		
<input type="checkbox"/> SINUS, FACE, NECK, ORBIT		
<input type="checkbox"/> Follow up — Trauma	<input type="checkbox"/> Pre- or post-OP evaluation	
<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Salivary gland mass or stone	
<input type="checkbox"/> Staging of malignancy	<input type="checkbox"/> Suspected thyroid mass	
<input type="checkbox"/> Known or suspected tumor (Palpable Neck Mass)	<input type="checkbox"/> Possible infection or abscess	
<input type="checkbox"/> Vascular abnormalities (AVM Aneurysm Dissection Stenosis, Obstruction)	<input type="checkbox"/> Immunocompromised patient or fungal infection warranting MR	
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Sinusitis Treatment	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Acute (less than 3 months)	<input type="checkbox"/> No antibiotic treatment	_____
<input type="checkbox"/> Chronic (more than 3 months)	<input type="checkbox"/> Failure single course antibiotics	_____
<input type="checkbox"/> Recurrent — (4 or more episodes/yr)	<input type="checkbox"/> Failure 2 or more courses antibiotics	_____
<input type="checkbox"/> UPPER/ LOWER EXTREMITIES		
<input type="checkbox"/> Recent trauma	<input type="checkbox"/> Pre- or post-OP evaluation	<input type="checkbox"/> Known or suspected tumor, metastasis
<input type="checkbox"/> Palpable soft tissue mass	<input type="checkbox"/> Soft tissue abscess	<input type="checkbox"/> Fracture evaluation
<input type="checkbox"/> Joint locking	<input type="checkbox"/> Tarsal coalition (feet)	<input type="checkbox"/> Suspected vascular abnormality (aneurysm dissection, thromboembolic disease, A-V malformation or fistula vasculitis, ischemia, pre or post op, venous thrombosis)
<input type="checkbox"/> Joint infection/inflammation	<input type="checkbox"/> Requested as part of arthrogram	<input type="checkbox"/> Other (describe): _____
<input type="checkbox"/> Avascular/Aseptic Necrosis	<input type="checkbox"/> Meniscal or labral tear	
<input type="checkbox"/> Charcot joint	<input type="checkbox"/> Abnormal plain film, bone scan, or ultrasound	
<input type="checkbox"/> Ligament, tendon, or fibrocartilage tear	<input type="checkbox"/> Rotator cuff tear (shoulder)	
Upper/Lower Extremities X-Ray Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not performed <input type="checkbox"/> Not performed in the past 2 months		
<input type="checkbox"/> PERSISTENT PAIN AND/OR DISABILITY (IF YES, CHECK REASON(S) BELOW)		
Prior Treatment (Check One)	Check all treatments that apply.	
<input type="checkbox"/> No prior treatment	<input type="checkbox"/> NSAIDS	<input type="checkbox"/> Physical therapy
<input type="checkbox"/> 3–5 weeks of treatment	<input type="checkbox"/> Splinting/brace/sling	<input type="checkbox"/> Chiropractic treatment
<input type="checkbox"/> 6 or more weeks of treatment	<input type="checkbox"/> Home exercise program	<input type="checkbox"/> Oral/Intra-articular Steroids
SECTION 6. DOCUMENT EXAM FINDINGS, PRIOR TESTS, RESULTS, AND DATES (INCLUDE TREATMENT DESCRIPTION FOR CONSERVATIVE THERAPY DURATION, PRIOR IMAGING, AND ANY TRAUMA HISTORY)		

*Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
Providers may attach any additional data relevant to medical necessity criteria.*