

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"/> Acute (less than 3 months) <input type="checkbox"/> Chronic (more than 3 months) <input type="checkbox"/> Recurrent — (4 or more episodes/yr)	<input type="checkbox"/> Sinusitis Treatment <input type="checkbox"/> No antibiotic treatment <input type="checkbox"/> Failure single course antibiotics <input type="checkbox"/> Failure 2 or more courses antibiotics	<input type="checkbox"/> Other (describe): _____ _____ _____
<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) <input type="checkbox"/> No prior treatment <input type="checkbox"/> 3–5 weeks of treatment <input type="checkbox"/> 6 or more weeks of treatment	Check all treatments that apply. <input type="checkbox"/> NSAIDS <input type="checkbox"/> Splinting/brace/sling <input type="checkbox"/> Home exercise program	<input type="checkbox"/> Physical therapy <input type="checkbox"/> Chiropractic treatment <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.