



1010 N.Bancroft Parkway, Suite 101  
Wilmington, DE 19805



2060 Limestone Road, Suite 2  
Wilmington, DE 19808



2501 Silverside Road, Suite 2  
Wilmington, DE 19810

## PREAUTHORIZATION REQUEST FORM

PHONE 302-246-2000

FAX 302-246-2010

### ORDERING PHYSICIAN INFORMATION

ORDERING PHYSICIAN NAME: \_\_\_\_\_

OFFICE CONTACT PERSON: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

### PATIENT INFORMATION

PATIENT NAME (Last, First): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PHONE: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

MEMBER ID: \_\_\_\_\_

**PLEASE ATTACH  
CLINICAL NOTES  
TO THIS REQUEST**

### AUTHORIZATION REQUEST INFORMATION

PART OF THE BODY TO BE EXAMINED: \_\_\_\_\_

REASON FOR PROCEDURE: \_\_\_\_\_

CPT CODE: \_\_\_\_\_ DIAGNOSIS CODE (ICD-9): \_\_\_\_\_

### PLEASE CHECK BOX FOR PROCEDURE TO BE AUTHORIZED:

MRI WITHOUT CONTRAST	<input type="checkbox"/>	CT WITHOUT CONTRAST	<input type="checkbox"/>
MRA WITHOUT CONTRAST	<input type="checkbox"/>	CT WITH CONTRAST	<input type="checkbox"/>
MRI WITH & WITHOUT CONTRAST	<input type="checkbox"/>	CT WITH & WITHOUT CONTRAST	<input type="checkbox"/>
MRA WITH & WITHOUT CONTRAST	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>

Please Do Not Write Below This Line

Name \_\_\_\_\_ Scheduled Yes

Authorization Approval \_\_\_\_\_ No

Contact Name \_\_\_\_\_

Approval Number \_\_\_\_\_ Date Received: \_\_\_\_\_

Denied Y \_\_\_\_\_ N \_\_\_\_\_ Reason Denied: \_\_\_\_\_