

Please fill out this form in its entirety, **SIGN**, and fax with any notes to:

ATTN SUSAN 319-626-7314



PLEASE NOTE

*THIS FORM DOES NOT REPLACE A PROVIDER ORDER

*ALL AREAS MUST BE COMPLETELY FILLED OUT

*THIS FORM MUST BE SIGNED AND THE PROVIDER ORDER MUST BE SIGNED

*****MEDICAL RECORDS AND A COPY OF THE INSURANCE CARD MUST BE SENT AS WELL AS ANY PREVIOUS IMAGING**

Date:
Requesting Provider:
Tax ID Number:
Best number to reach provider/nurse:

Staff Member:
Provider NPI:
Fax Numer:

Patient Name:
Insurance Carrier #1:
Insurance Carrier #2:

Patient Date of Birth:
Policy Nuber:
Policy Number:

Site where procedure is being performed: Corridor Muscatine Other _____

Requested Exam / Modality / Body Part: MRI MRA CT CTA

Contrast: With Without With /Without

Body Part: _____ **Diagnosis Code:** _____

1. What does the provider want to rule out?
2. Symptoms / Duration;(i.e. injury? If so, when did the injury occur?)
3. Any previous pertinent studies for this diagnosis/symptom? (ECHO/EKG/Imaging?) If so, when and where?
4. Any treatments performed for this diagnosis/symptoms (PT, Meds) Duration of treatment?
5. Any relevant medical history for this diagnosis/symptom?

I give my permission for Susan Rechkemmer to retain prior authorization on behalf of the requesting provider's office:

Signature	Title	Date
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FOR INTERNAL USE ONLY

Auth Number:	Rep:	Ref. Call #	Duration:
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