RADCON | **AUTHORIZATION REQUEST FORM**

1 CHOOSE A SITE LOCATION

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2 PATIENT INFORMATION

Patient First Name:______________________ Patient Last Name:______________________

DOB: _____ / _____ / _____ Gender (Circle): **M F**

Insurance Company Name: ______________________

Policy ID #______________________

3 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: ______________________

Fax #: ______________________

INS Provider / Tax ID#:______________________

REFERRED TO

Name: ______________________

City: ______________________

State: ______________ Zip: ______________

Diagnosis 1: ______________________ ICD9 Code 1: ______________

Diagnosis 2:______________________ ICD9 Code 2:______________

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): **(MANDATORY)**

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Findings from prior radiology exams: ______________________

4 AUTHORIZATION REQUEST FOR RADIOLOGY **(MANDATORY)**

EXAM TYPE: ❑ MRI ❑ MRA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Brachial Plexus
❑ Brain
Hormone Levels
____
❑ Breast, Bilateral
❑ Breast, Bilateral Implant Evaluation
❑ Breast, Bilateral Cancer Evaluation
❑ Chest
❑ MRCP
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary

❑ Sinuses
Duration of symptoms
____
Type of antibiotics
____
Duration of antibiotics
____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Ankle Rt ___ LT ___
❑ Elbow Rt ___ LT ___
❑ Foot Rt ___ LT ___
❑ Hand Rt ___ LT ___
❑ Hip Rt ___ LT ___
❑ Knee Rt ___ LT ___
❑ Shoulder Rt ___ LT ___
❑ Wrist Rt ___ LT ___

❑ Other CPT Code: ______________

EXAM TYPE: ❑ CT ❑ CTA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Abdomen/Pelvis
❑ Brain
❑ Carotid
❑ Chest
❑ Coronary CTA
❑ Head
❑ Heart
❑ Kidney
❑ Urography

❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
____
Type of antibiotics
____
Duration of antibiotics
____

❑ C Spine
❑ L Spine
❑ T Spine

❑ Upper Extremity ______________
❑ Lower Extremity ______________
Date of Injury: _____ / _____ /_____
Date of onset of symptoms: _____ / _____ /_____
Date of PT start: _____ / _____ /_____
Medications: ______________________

❑ Other ______________ CPT Code:__________

❑ With 3D Recons

❑ Please notify me __________ days before authorization expiration.

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

5 **Fax completed forms to: (855) RADCON2** (723-2662)

RADCON RADIOLOGY CONSULTANTS OF NEW JERSEY, INC.

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Moorestown, New Jersey 08057
Phone: (855) RADCON1 (723-2661)