Princeton Radiology
Excellence in Imaging

PRE-AUTHORIZATION DEPARTMENT
p: 609.655.1448
Rosalie ext. 6671 | Jessica ext. 6674 | Dennis ext. 6675 | Dionne ext. 6677
fax: 609.436.6441

Date: Time:

PRE-AUTHORIZATION REQUEST FORM

Physician: NPI:

Address:

City: State: Zip:

Office Phone: Fax:

Who should we contact if we require additional information?

Name: Phone: Fax:

Please fax this cover sheet & the items below to 609.436.6441

1. Prescription – with diagnosis.
2. Copy of patient's insurance card – front and back.
3. Clinical History – including symptoms, duration, prior treatment and/or EMR notes with patient demographics.

Questions? Please contact us at 609.655.1448 and we would be happy to help.

Patient Name: Date of Birth:

Address:

City: State: Zip:

Home Phone: Cell:

Insurance(s) ID#: Primary:

Secondary:

CPT Code/Exam: Diagnosis:

Prior Studies: Last Office Visit:

STAT Order ❒ Yes ❒ No

Comments:

By submission of this request to Princeton Radiology. Provider hereby consents and authorizes Princeton Radiology to act on its behalf and contact the patient's insurance carrier to obtain pre-authorization for the requested studies.

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