SOUTH JERSEY RADIOLOGY ASSOCIATES (Please ATTACH Prescription)

ONCOLOGY AUTHORIZATION REQUEST FORM

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

DOB: _____ / _____ / _____ Gender (Circle): M F Patient Phone Number _____

Insurance Company Name: _____

Policy ID# _____

☐ COPY OF INSURANCE CARD REQUIRED (front & back) ☐ COPY OF PRESECRIPTION / ELECTRONIC ORDER REQUIRED

PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____

City: _____ Zip: _____

Fax #: _____

NPI # / Tax ID#: _____

REFERRED TO

Name: SOUTH JERSEY RADIOLOGY

State: **New Jersey** Zip: _____

Reason for Exam: _____

Diagnosis, Staging, Re-staging, Suspected Recurrence, Surveillance

Diagnosis 1: _____ ICD10 Code 1: _____

Diagnosis 2: _____ ICD10 Code 2: _____

For new cancer diagnosis, please include type of cancer and date of diagnosis: _____

_____

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

_____

_____

Findings from prior radiology exams: _____

Metastatic Disease: ☐ Yes ☐ No

Suspicion of recurrence or progression based on signs, symptoms or imaging findings: ☐ Yes ☐ No

Tissue diagnosis: ☐ Yes ☐ No

Rising Tumor Markers: ☐ Yes ☐ No If yes, please indicate which one(s) and value(s)_____

Chemotherapy (Start Date): _____ / _____ / _____ Chemotherapy (End Date): _____ / _____ / _____

Radiation (Start Date): _____ / _____ / _____ Radiation (End Date): _____ / _____ / _____

AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

☐ **PET/CT**	☐ **CT**	☐ **MRI**
☐ Brain	☐ With & Without Contrast	☐ With & Without Contrast
☐ Cardiac	☐ Without Contrast	☐ Without Contrast
☐ Oncology (Skull - Mid Thigh)	☐ With Contrast	☐ With Contrast
Type of Cancer _____		
☐ Melanoma (whole body)	☐ Abdomen	☐ Abdomen ☐ Neck
☐ Other _____	☐ Chest, Thorax	☐ Brain ☐ Pelvis
CPT Code: _____	☐ Head	☐ Breast, Bilateral
	☐ Neck	☐ Chest, Thorax
Isotope agent:	☐ Pelvis	☐ Head
☐ FDG ☐ NaF	☐ Other _____	☐ Other: _____
	CPT Code: _____	CPT Code: _____

Submitted by: _____ Phone: _____ Date: _____ /_____ /_____

FAX completed forms to: (856) 772-0268 Rev 006/01/18 td