South Jersey Radiology Associates Authorization Request Form (CT CHEST)

Please fax this completed document along with medical records, imaging, tests, etc.to (856)772-0268. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination

SJRA is unable to obtain precertification for URGENT/STAT requests, No-fault (MVA), Workers Compensation and/or non-participating insurance carriers.

Patient Information

First Name:	Middle Initial:	Last Name:
DOB (mm/dd/yyyy)		Gender: ☐Male ☐Female
Address:		Apt#:
City:	State:	Zip:
Patient Phone Number:		
Health Insurance Plan:		
Member ID:		Group ID:
COPY OF INSURANCE CARD REQUIRED (front & back)	**COPY OF PRESCRIPTION/ ELECTRONIC ORDER REQUIRED**	

Ordering Provider

First Name:		Last Name:
Primary Specialty:	TIN:	Individual NPI:
Provider Phone:		Provider Fax:
Address:		Suite Number:
City:	State:	Zip:
Office Contact:		Extension:

Site

Group Name: **South Jersey Radiology Assoc.**	State: **New Jersey**	TIN:	**221899118**	NPI:	**1477551653**
Phone: **(888) 909-7572**		Fax: **(856) 772-0268**			

Diagnosis and Procedure(s)

Diagnosis 1:		ICD 10 Code 1:		
Diagnosis 2:		ICD 10 Code 2:		
Diagnosis 3:		ICD 10 Code 3:		
Check all applicable CPT Codes:	CT CHEST:	☐w/o 71250	☐w/ 71260	☐w/wo 71270
	CTA CHEST:	☐71275		
	CT CHEST SCREENING	☐G0297		
	OTHER (please specify):	☐		

Contact

Date of most recent office visit or other contact with provider:
Type of most recent documented contact with provider: ☐ Office Visit ☐ Hospital ☐ Phone call with provider ☐Other

Clinical Information

Is this for cancer diagnosis?		☐Yes	☐No	☐Don't Know
Is there evidence of cancer in the chest?		☐Yes	☐No	☐Don't Know
Is there a new nodule or mass on chest x-ray or imaging study?		☐Yes	☐No	☐Don't Know
Was a chest x-ray done within the last 4 weeks and read by a radiologist?		☐Yes	☐No	☐Don't Know
Has a chest CT been done within the past year?		☐Yes	☐No	☐Don't Know
Is chest pain present?		☐Yes	☐No	☐Don't Know
Has a D-dimer been done?		☐Yes	☐No	☐Don't Know
Smoking status:	☐Current Smoker	☐Former Smoker	☐Never Smoked	☐Don't Know
If current or former smoker:	Number of packs per day:		Number of years smoking:	
If former smoker, has it been over 15 years?		☐Yes	☐No	☐Don't Know

Is there any additional history or clinical facts supporting the requested examination? Attach additional clinical information if needed.

Submitted by:	Phone:	Date:

FAX completed forms to (856)772-0268