South Jersey Radiology Associates Authorization Request Form (ALL STUDIES*)

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.

***This is NOT the appropriate form for: CT Abdomen/Pelvis, Chest or MRI Breast, Extremity Joint, Spine, or MRI ordered for MS**

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:
Requested CPT Code(s):	
CPT Code(s) Description:	

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

If this study is for a confirmed cancer; please specify the type:

Symptoms and Complaints:	Duration:

Findings on Physical Exam (include proactive tests if applicable):

Patient/ Family History Applicable to Imaging Request:

Prior Test (including x-ray, US, CT, MRI); treatments (surgery, physical therapy etc.); Biopsy Results Related to the Current Problem:

Test, Intervention, or Surgery:	Date:	Results:

If Preoperative, List Surgery or Procedures Planned:	Date:

Clinical Information

Results of Pertinent Recent Lab Tests Relevant to the Current Problem:

Test:	Date:	Result:

Medications Used for the Current Problem:

Medication:	Duration and Dates:	Effective?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

How long has there been physician-directed treatment or observation since the onset of this episode? (Physician directed treatment might include pain medicine, steroids, steroid injections, physical therapy and/or physician monitored home exercise program.)

☐No physician directed treatment

☐Don't know

☐Enter number of weeks:

How have symptoms changed with physician directed treatment or observation?

☐No physician directed treatment or observation

☐Symptoms have worsened

☐Symptoms have improved

☐Don't know

☐Symptoms have stayed the same

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