South Jersey Radiology Associates Authorization Request Form (MRI BREAST)

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:

MRI BREAST BILATERAL:	☐w/wo 77049	☐w/o 77047(Implant Rupture)
MRI BREAST UNILATERAL:	☐w/wo 77048	☐w/o 77046 (Implant Rupture)
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 an annual or screening MRI? (Hint: no breast lesion or problems)	☐Yes	☐ No	☐ Don't Know
Is there a personal history of breast cancer?	☐Yes	☐ No	☐ Don't Know
Is there a known breast lesion?	☐Yes, mass on physical exam ☐Yes, abnormal mass on mammogram or ultrasound ☐Yes, mass on previous MRI or CT	☐No ☐Don't Know	
Date of last breast imaging study?	☐Date:_____ ☐Previous imaging not done	☐Performed date unknown ☐Unknown if imaging was done	
Is a biopsy planned?	☐Yes	☐No	☐Don't Know
Is this MRI for a MRI guided biopsy?	☐Yes	☐No	☐Don't Know
Has a breast biopsy been performed within the last 6 months?	☐Yes	☐No	☐Don't Know
Is there a new diagnosis of breast cancer proven by biopsy?	☐Yes	☐No	☐Don't Know
What is the patient's lifetime risk percentage for breast cancer and what model was used?			
Is there a family history of breast cancer?	☐Yes	☐No	☐Don't Know
If there is a family history of breast cancer; what's the relation of the family member (mother, grandmother, etc.) and what age was he/she diagnosed:			

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