South Jersey Radiology Associates Authorization Request Form (MRI Extremity Joint Upper/Lower)

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 LOWER EXTREMITY JOINT	☐w/o 73721	☐w/wo 73723
	MRI UPPER EXTREMITY JOINT	☐w/o 73221	☐w/wo 73223
	OTHER (please specify):	☐	

Contact

Date of most recent office visit or other contact with provider: ☐Date: ☐Don't know

Type of most recent documented contact with provider: ☐ Office Visit ☐ Hospital ☐ Phone call ☐Other

What was the date of the FIRST office visit for this episode of symptoms? ☐Date: ☐Don't know

Has a specialist evaluation been completed? ☐Yes (please specify): ☐No ☐Don't know

Clinical Information

Has there been a recent injury? ☐Yes(please specify) ☐No ☐Don't know

Has an X-ray been done? ☐Yes ☐No ☐Don't Know

Is there a person history of cancer other than ordinary skin cancer? ☐Yes ☐No ☐Don't Know

Is this study to evaluate arthritis? ☐Yes ☐No ☐Don't Know

What is the range of motion? ☐Full Motion ☐Limited/Painful ☐Don't know

Has there been a period of conservative treatment? ☐Yes (please specify number of weeks):

☐None ☐Don't know

Indicate type of physician directed treatment. Select all that apply:

☐N-S-A-I-D-S and/or oral steroids ☐Splinting/Bracing

☐Steroid injections ☐Home exercise or physical therapy

☐Pain medication other than N-S-A-I-D-S ☐No treatment

☐Don't know ☐Other (please specify):

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