South Jersey Radiology Associates Authorization Request Form (MRI-Multiple Sclerosis)

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 CERVICAL SPINE:	☐w/o 72141	☐w/wo 72156
MRI THORACIC SPINE:	☐w/o 72146	☐w/wo 72157
MRI LUMBAR SPINE:	☐w/o 72148	☐w/wo 72158
MRI BRAIN	☐w/o 70551	☐w/wo 70553
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

	Date of the first office visit with any physician for this episode:
	Date of the most recent office visit for this episode:
	Is this request for suspected or confirmed (established) MS? ☐Suspected ☐Established ☐Don't Know
	If MS is a confirmed (established) diagnosis, is immunotherapy currently being used? ☐No, this is for suspected MS ☐Confirmed MS with use of immunotherapy ☐Confirmed MS, not currently using immunotherapy ☐Don't Know
	Have any of the following neurological deficits occurred in the past month? Choose all that apply: ☐Sensory problems ☐Bowel or bladder problems ☐Hemiparesis (muscular weakness of one half of body) ☐Gait or balance problems ☐Vision disturbances (double vision, loss of vision, etc.) ☐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