South Jersey Radiology Associates Authorization Request Form (MRI SPINE*)

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 MRI ordered for Multiple Sclerosis**

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
	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 request to rule out or evaluate any of the following? Please choose only the primary reason.	☐Multiple Sclerosis (This is the incorrect fax form. Please use the MRI Multiple Sclerosis form) ☐Back/neck pain ☐Known or suspected spine trauma ☐Metastatic cancer ☐Surgical planning/Pre-op ☐None of the above ☐Don't know
	Date of the first office visit with any physician for this episode:	
	Date of the most recent office visit for this episode:	
	Has there been a history of spine trauma from any of the following?	☐Strain from lifting, turning head, minor fall ☐Fall from height over 3 feet or 5 stairs ☐Motor Vehicle Accident (MVA) **SJRA cannot process** ☐Head trauma with loss of consciousness ☐Diving accident (diving board, etc.) ☐None of the above ☐Don't know
	When did the spine trauma occur?	☐Less than a month ago ☐One to three months ago ☐Greater than three months ago ☐Don't know
	What are the current symptoms? (Select all that apply)	☐No Symptoms ☐Lower Back Pain ☐Arm pain that goes into forearm or hand ☐Neck pain ☐Leg pain that goes below the knee ☐Upper back pain (middle or upper back) ☐Hip or thigh pain ☐None of the above ☐Don't know
	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 improved ☐Symptoms have stayed the same ☐Symptoms have worsened ☐Don't know

Clinical Information	Were any of the following found by a medical professional on a physical exam performed for this episode? Choose all that apply:	☐No physical exam performed ☐Upper motor neuron signs (Hoffman's, Babinski, Hyperreflexia) ☐Decreased reflexes in upper extremity(ies) ☐Decreased reflexes in lower extremity(ies) ☐Incontinence of bowel/bladder ☐Foot drop ☐Muscle strength four out of five or less in one or both arms documented on the exam by the physician ☐Muscle strength four out of five or less in one or both legs documented on the exam by the physician ☐None of the above ☐Don't know
	Is any of the following present in the medical history? Choose all that apply:	☐Cancer that has been treated within the last ten years other than squamous or basal cell skin cancer. ☐Immunosuppression (Hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis) ☐IV drug use ☐Cervical spine surgery ☐Thoracic spine surgery ☐Lumbar spine surgery ☐None of the above ☐Don't know
	Has a CT or MRI of the spine been performed in the last 6 months? Choose all that apply:	☐No CT or MRI of the spine has been performed ☐CT or MRI Cervical spine Date performed: ☐CT or MRI Thoracic spine Date performed: ☐CT or MRI Lumbar spine Date performed: ☐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