PREAUTHORIZATION/ RQI REQUEST FAX FORM

Instructions:

If Urgent request please call AIM

Please complete ALL information requested on this form, incomplete forms will be returned to sender.

TO: **AMERICAN IMAGING MANAGEMENT PREAUTH/RQI DEPARTMENT**
www.americanimaging.net

FAX #: **800-610-0050**

FROM: Contact Person	Phone #:	
	Fax #:	

Subscriber (Insurance Holder) and Patient Information

Subscriber Name:

Last:_____ **First:**_____

ID #: (include alpha prefix)_____

SSN:_____

Health Plan Name: _____

Group #:_____ Product type: ☐PPO ☐POS ☐HMO ☐Other: _____

Patient Name:

Last :_____**First:**_____

DOB:_____/_____/_____ **SEX:** **M** **F**

RELATIONSHIP TO SUBSCRIBER: **SELF** **SPOUSE** **CHILD**

Referring Physician Information (The physician who is ordering the exam)

Name:
Last:_____**First:**_____

Phone: (_____**)**_____

Fax: (_____**)**_____

Address: _____

Specialty:_____

Provider Information (Where the service will be provided)

Name of Facility:_____

Address: _____

Phone: (_____**)**_____

Procedure(s) Information (please include CPT Code, if available)

Date of Procedure: _____/_____/_____ **Procedure:** _____ **CPT Code:** _____

Date of Procedure: _____/_____/_____ **Procedure:** _____ **CPT Code:** _____

Date of Procedure: _____/_____/_____ **Procedure:** _____ **CPT Code:** _____

Clinical Information *(all info must be completed)*

1. Patient's diagnosis or symptoms (include duration, frequency, and intensity)_____
2. What is the physician suspecting or ruling out with the requested study? _____
3. Has the patient received treatment for the above symptoms (include duration and type)? _____
4. List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), include results:_____
5. Is this injury related? ☐ Yes ☐ No Date and type of Injury: _____
6. Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis? ☐ Yes ☐ No
   Cancer type:_____