# Prior Authorization Request Form

Please fill out this form in its entirety, **SIGN**, and fax with any notes to:
ATTN SUSAN 319-545-7309

Corridor RADIOLOGY Muscatine RADIOLOGY

## PLEASE NOTE

*THIS FORM DOES NOT REPLACE A PROVIDER ORDER
*ALL AREAS MUST BE COMPLETELY FILLED OUT
*THIS FORM MUST BE SIGNED AND THE PROVIDER ORDER MUST BE SIGNED
***MEDICAL RECORDS AND A COPY OF THE INSURANCE CARD MUST BE SENT AS WELL AS ANY PREVIOUS IMAGING

Date:
Requesting Provider:
Tax ID Number:
Best number to reach provider/nurse:

Staff Member:
Provider NPI:
Fax Number:

Patient Name:
Insurance Carrier #1:
Insurance Carrier #2:

Patient Date of Birth:
Policy Number:
Policy Number:

Site where procedure is being performed: ☐ Corridor ☐ Muscatine ☐ Other _____

**Requested Exam / Modality / Body Part:** ☐ MRI ☐ MRA ☐ CT ☐ CTA

**Contrast:** ☐ With ☐ Without ☐ With / Without

**Body Part:** _____ **Diagnosis Code:** _____

1. What does the provider want to rule out?

2. Symptoms / Duration;(i.e. injury? If so, when did the injury occur?)

3. Any previous pertinent studies for this diagnosis/symptom? (ECHO/EKG/Imaging?) If so, when and where?

4. Any treatments performed for this diagnosis/symptoms (PT, Meds) Duration of treatment?

5. Any relevant medical history for this diagnosis/symptom?

I give my permission for Susan Koberle to retain prior authorization on behalf of the requesting provider's office:

_____

**Signature** **Title** **Date**

FOR INTERNAL USE ONLY

Auth Number: Rep: Ref. Call # Duration: