



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: _____	Patient Name: Last : _____ First: _____
ID #: (include alpha prefix) _____	DOB: ____ / ____ / ____ SEX: M F
SSN: _____	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD
Health Plan Name: _____	
Group #: _____ Product type: <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____	

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

Provider Information (Where the service will be provided)

Name: Last: _____ First: _____	Name of Facility: _____
Phone: (_____) _____	Address: _____
Fax: (_____) _____	Phone: (_____) _____
Address: _____	
Specialty: _____	

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)

- Patient's diagnosis or symptoms (include duration, frequency, and intensity) _____

- What is the physician suspecting or ruling out with the requested study? _____

- Has the patient received treatment for the above symptoms (include duration and type)? _____

- List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), include results: _____

- Is this injury related? Yes No Date and type of Injury: _____
- Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis? Yes No
Cancer type: _____