

Prior Authorization Request



****Chart Notes Required****

Please fax to: 503-574-6464 or 800-989-7479 | Questions please call: 503-574-6400 or 800-638-0449

For High Tech Imaging	American Imaging Management (AIM) Phone: 800-920-1250 http://www.americanimaging.net/goweb/ For Registration: Providence PIN #: 045-83169	
Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:	Date of Service:	Date Span Requested:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Servicing Facility:		TIN#:
Address:		NPI#:
Requested Item/Service:		
ICD-10 Code(s):		CPT Code(s):
Requested Services: <input type="checkbox"/> Office Visits, # of visits: _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Diagnostic <input type="checkbox"/> Facility Auth Only <input type="checkbox"/> DME Other _____		
Type of Service: <input type="checkbox"/> Elective Inpatient Admit <input type="checkbox"/> Elective Outpatient Surgery <input type="checkbox"/> Office Surgery <input type="checkbox"/> Outpatient Diagnostics <input type="checkbox"/> ASC		
<u>Expedite</u> - defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. Request must include supporting documentation to substantiate an expedited review. Explanation Required:		
In-Network Benefits: Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient Date last seen _____ Explanation Required:		
REQUIRED Contact Information:		
Name:	Phone #:	Fax#:

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