RADCON RADIOLOGY CONSULTANTS OF NEW JERSEY, INC.

302 Harper Drive, Suite 101
Moorestown, New Jersey 08057
Phone: (855) RADCON1 (723-2661)
Fax: (855) RADCON2 (723-2662)

AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION

Patient First Name:______________________________ Patient Last Name:____

DOB: _______ / _______ / _______ Gender (Circle): M F

Insurance Company Name: ____

Policy ID #____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: ____

Fax #: ____

INS Provider / Tax ID#:___________________________

REFERRED TO

Name: ____

City:____

State:____________________ Zip: ___________________

Diagnosis 1: ____ ICD9 Code 1: ___________________________

Diagnosis 2:____ ICD9 Code 2:____________________________

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): **(MANDATORY)**

____

____

Findings from prior radiology exams: ____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

EXAM TYPE: ❑ MRI ❑ MRA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Brachial Plexus
❑ Brain
Hormone Levels
____
❑ Breast, Bilateral
❑ Breast, Bilateral Implant Evaluation
❑ Breast, Bilateral Cancer Evaluation
❑ Chest
❑ MRCP
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary

❑ Other

❑ Sinuses
Duration of symptoms
____
Type of antibiotics
____
Duration of antibiotics
____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Ankle Rt ___ LT ___
❑ Elbow Rt ___ LT ___
❑ Foot Rt ___ LT ___
❑ Hand Rt ___ LT ___
❑ Hip Rt ___ LT ___
❑ Knee Rt ___ LT ___
❑ Shoulder Rt ___ LT ___
❑ Wrist Rt ___ LT ___

CPT Code: _______________

EXAM TYPE: ❑ CT ❑ CTA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Abdomen/Pelvis
❑ Brain
❑ Carotid
❑ Chest
❑ Coronary CTA
❑ Head
❑ Heart
❑ Kidney
❑ Urography

❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
____
Type of antibiotics
____
Duration of antibiotics
____

❑ C Spine
❑ L Spine
❑ T Spine

❑ Upper Extremity _____________
❑ Lower Extremity _____________

Date of Injury: _____ / _____ /_____
Date of onset of symptoms: _____ / _____ /_____
Date of PT start: _____ / _____ /_____
Medications: ____

❑ Other ____________________ CPT Code:__________
❑ With 3D Recons

❑ Please notify me ___________ days before authorization expiration.

Submitted by: ________________________________ Phone #: ____________________ Date: _______ / _______ / _______

4 **Fax completed forms to: (855) RADCON2** (723-2662)