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)

ONCOLOGY 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: ___________________

Reason for Exam: ____

Diagnosis, Staging, Re-staging, Suspected Recurrence, Surveillance

Diagnosis 1: ____ ICD9 Code 1: ___________________________

Diagnosis 2:____ ICD9 Code 2:___________________________

For new cancer diagnosis, please include type of cancer and date of diagnosis:___________________________________

____

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

____

____

Findings from prior radiology exams: ____

Tissue diagnosis: ❑ Yes ❑ No

Rising Tumor Markers: ❑ Yes ❑ No If yes, please indicate which one(s) and value(s)___________________________

Chemotherapy (Start Date): _______ / _______ / _______ Chemotherapy (End Date): _______ / _______ / _______

Radiation (Start Date): _______ / _______ / _______ Radiation (End Date): _______ / _______ / _______

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

❑ PET/CT

❑ Brain
❑ Cardiac
❑ Oncology (Skull - Mid Thigh)
Type of Cancer_______________
❑ Melanoma (whole body)
❑ Other _____________________
CPT Code:______________________

Isotope agent:
❑ FDG ❑ NaF

❑ CT

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen
❑ Chest, Thorax
❑ Head
❑ Neck
❑ Pelvis
❑ Other _____________________
CPT Code:______________________

❑ MRI

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen ❑ Neck
❑ Brain ❑ Pelvis
❑ Breast, Bilateral
❑ Chest, Thorax
❑ Head
❑ Other _____________________
CPT Code:______________________

❑ Please notify me __________ days before authorization expiration.

Submitted by: ____________________________ Phone #: ______________________ Date: _______ / _______ / _______

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