

Instructions:

Please complete ALL information requested on this form. Forms with incomplete information cannot be processed.

TO: AMERICAN IMAGING MANAGEMENT PRECERTIFICATION DEPARTMENT

FAX #: 800-610-0050

www.americanimaging.net

FROM: Contact Person	Phone #:	
	Fax #:	

Subscriber (Insurance Holder) and Patient Information

Subscriber Name: Last: _____ First: _____	Patient Name: Last : _____ First: _____
ID #/SSN: _____	DOB: ____/____/____ SEX: M F
Health Plan: _____ Group #: _____	RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD

Referring Physician Information <i>(The physician who is ordering the exam)</i>	Provider Information <i>(Where the service will be provided)</i>
---	--

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)

- Differential Diagnosis: _____ ICD-9 Code: _____
- Patient Symptoms (include duration): _____

- Relevant physical exam findings: _____

- Pertinent labs, imaging or other tests (include results): _____
- List all treatment for this condition (include type, duration and response): _____

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