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PHYSICIAN SERVICES AUTHORIZATION REQUEST FORM

*Please choose one

☐ Needs Authorization

☐ Already Authorized

** Fields marked with an asterisk are required.*

(Note: Claim # is required.) Please provide as much info as possible to expedite the process.

Authorization Request For: ☐ Radiology ☐ EMG & NCS ☐ DME ☐ Physical Therapy

☐ Transportation: ☐ Language Services _____ ☐ Other _____

☐ Ambulatory/Sedan ☐ Commercial flight and hotel coordination ☐ Wheelchair

☐ Air Ambulance ☐ Non-emergency Ambulance ☐ Discharges ☐ Unknown ☐ Other _____

Notes /Location: _____

***Patient First & Last Name:** _____ ***D.O.B:** _____

***Address:** _____ ***Primary Phone:** _____

_____ **Secondary Phone:** _____ **Other Phone:** _____

Employer: _____ ***Gender:** ☐ M ☐ F **Date of Injury:** _____

Employer Phone: _____ **Fax :** _____

***Insurance Co:** _____ ***Claim #:** *(If available)* _____

Other information, *if Available*

Insurance Co. Address: _____ **Adjuster Name:** _____

_____ **Adjuster Email:** _____

_____ **Phone:** _____ **Fax:** _____

Practice Name: _____ **Office Contact:** _____ **Phone:** _____

Treating Physician: _____ **Office Contact Email:** _____

Diagnosis 1: _____ **ICD-10 Code 1:** _____

Diagnosis 2: _____ **ICD-10 Code 2:** _____

Clinical Information/Special Instructions:(e.g. open/closed machine, etc.):

_____

RADIOLOGY/ EMG & NCS

Exam Type: ☐ MRI ☐ MRA ☐ CT ☐ Extended Radiology (please specify) _____

☐ W/ & W/O Contrast ☐ W/ Contrast ☐ W/O Contrast ☐ EMG & NCS

Body Part: _____ RT ☐ LT ☐ **CPT:** _____

Body Part: _____ RT ☐ LT ☐ **CPT:** _____

Body Part: RT ☐ LT ☐ **CPT:**

DME / OTHER

Type /Body Part: _____

_____

PT

Duration (Weeks): _____ **Frequency (Times/wk):** _____ **Body Part:** _____ RT ☐ LT ☐

PATIENT NOTES, PRESCRIPTION AND A COPY OF WORKERS' COMPENSATION PANEL *(If Applicable)* MUST ACCOMPANY THIS AUTHORIZATION REQUEST.

PLEASE FAX FORM TO: 973-939-3810 OR Submit by Email