

If an urgent request, please call AIM at 800-552-0020

Please complete ALL information requested on this form. Incomplete forms will be returned to sender.

TO: AMERICAN IMAGING MANAGEMENT PREAUTHORIZATION/ RQI DEPARTMENT
www.americanimaging.net

<i>Ordering Physician Information</i>	<i>Patient Information</i>
Last Name: _____ First: _____ Phone: _____ Fax: _____ Address: _____ Specialty: _____ Contact person: _____	Last Name: _____ First Name: _____ DOB: _____ SEX: M F Priority Health Member Number: _____
<i>Provider Information (Where the service will be provided)</i>	
Facility Name: _____ Address: _____	
<i>Procedure(s) Information</i>	
Procedure Date: _____	Procedure: _____ CPT-4 (optional) _____
Procedure Date: _____	Procedure: _____ CPT-4 (optional) _____
Procedure Date: _____	Procedure: _____ CPT-4 (optional) _____

Clinical Information (Incomplete form will be returned to sender)

1. Patient's diagnosis or symptoms (include duration, frequency, and intensity) _____

2. What is the physician suspecting or ruling out with the requested study? _____

3. Has the patient received treatment for the above symptoms (include duration and type)? _____

4. List any previous relevant testing (diagnostic imaging), include results: _____

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