

Pre-Authorization Request for Information Form



Member Information		
Member's ID:	Member's Address:	
Member's Name: (First/MI/Last)	City:	
Requested Examination:	State/Province:	Postal Code:
Anticipated Date of Service:	Country/Region:	
Physician Information		
Ordering Physician's Name:		
Street Address:	State/Province:	Postal Code:
Physician's Telephone Number:		
Medical Information		
Details Justifying Examination:		
Symptoms and Their Duration:		
Conservative Treatment Patient Has Already Completed (e.g. physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications)		
Preliminary Procedures Already Completed (e.g. X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation)		
Reason the Study is Being Requested (e.g. further evaluation, rule out a disorder)		
Comments:		

Please attach or fax the following information to :

- Clinical Notes
- X-Ray Reports
- Previous CT/MRI Reports
- Specialist Reports/Evaluation
- Ultrasound Reports