

CT/CTA/MRI/MRA PRIOR AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS			
Patient Name (First, Last):		DOB:	
Health Plan:	Member ID:	Group #:	
SECTION 2. ORDERING PROVIDER INFORMATION			
Physician Name (First, Last):			
Primary Specialty:	NPI:	Tax ID:	
Phone #:	Fax #:	Contact Name:	
SECTION 3. FACILITY INFORMATION			
Facility Name:		Facility Tax ID:	NPI:
Address:	City:	State:	Zip:
Phone #:	Fax #:	Date of Service:	
SECTION 4. EXAM REQUEST			
☐ CT	☐ MRI	☐ CTA	☐ MRA
CPT Code(s):			
Description:			
ICD Diagnosis Code(s):			
Description:			
Date of first office visit for this condition with any provider:			
Date of most recent office visit for this condition with any provider:			
SECTION 5. SELECT APPLICABLE BODY REGION AND CHECK REASON(S) FOR STUDY (CHECK ALL THAT APPLY)			
☐ ABDOMINAL/ PELVIS			
Abd/Pelvis Combination Study ☐ Yes ☐ No			
☐ Acute Pain (less than 48 hrs) ☐ Hematuria ☐ Inflammatory Bowel Disease consistent with Appendicitis, Diverticulitis, or Abscess ☐ Suspected Hemochromatosis ☐ Abdominal or Pelvic Mass ☐ Suspected Vascular Disease, Mesenteric Ischemia ☐ Suspected Renal Artery Stenosis ☐ Hernia ☐ Pancreatic or adrenal mass seen on other imaging	☐ Chronic Pain (more than 48 hours) ☐ Abdominal/Pelvic Trauma ☐ Anemia ☐ Fever of Unknown Origin [FUO] ☐ Ascites ☐ Prostate Neoplasm ☐ Pre- or post-OP evaluation ☐ Lower extremity edema ☐ Significant weight loss (10% of body weight over 6 months or less) ☐ Transplant	☐ Kidney/Urethral Obstruction or Calculus ☐ Jaundice, Abnormal Liver Function Tests ☐ Endometrial Abnormality ☐ Staging (malignancy) ☐ Suspected Aneurysm/Dissection/AVM ☐ MRCP ☐ Lower extremity claudication ☐ Suspected abnormality of pelvic bones or muscular structures ☐ Pelvic Floor Dysfunction ☐ Other (describe): _____	
☐ SPINE			
☐ Neurological Deficits ☐ Known or suspected infection ☐ Persistent Pain ☐ Radiculopathy ☐ Possible Fracture ☐ Other (describe): _____	☐ Trauma or recent injury ☐ Known or suspected tumor on bone scan or x-ray ☐ Unilateral Muscle wasting ☐ Pre- or post-OP Evaluation ☐ Suspected Multiple Sclerosis (not applicable for CT or for CT or MRI of lumbar region)		
PRIOR /CURRENT TREATMENT(S)			
Check One (Prior Treatment)		Check all treatments that apply	
☐ No Prior Treatment ☐ 3–5 weeks of treatment ☐ 6 or more weeks of treatment		☐ NSAIDS ☐ Spine Injections ☐ Home Exercise Program ☐ Physical Therapy ☐ Chiropractic Treatment ☐ Oral Steroid	
☐ BREAST MRI DIAGNOSTIC		☐ BREAST MRI SCREENING	
☐ Abnormal/inconclusive mammogram or ultrasound ☐ Suspected Recurrence of Breast Cancer ☐ Mass evaluation post surgery	☐ Evaluate extent of invasive cancer ☐ Evaluation axillary node metastasis ☐ Dense breast tissue	☐ Evaluation of symptomatic patients with breast implants, for detection of implant rupture ☐ Positive Margins Post-OP ☐ 6 months follow up abnormal MRI (birads3)	

☐ REQUEST FOR ANNUAL SCREENING FOR BREAST CANCER (If yes, check reason(s) below)		
☐ Lifetime risk 20% or greater as defined by BRACA PRO or other models ☐ BRCA1 and BRCA2 mutation	☐ History of lobular or ductal carcinoma in situ on biopsy ☐ Li-Fraumeni Syndrome, Cowden Syndrome	☐ Radiation therapy to chest between ages 10–30 ☐ Bannayan-Riley-Ruvucaba Syndrome
☐ BRAIN/HEAD		
☐ Known or suspected tumor/mass or metastasis ☐ Recent significant head trauma ☐ Known or suspected stroke ☐ Brain infection or abscess ☐ Abnormal neurological exam	☐ New onset of seizures ☐ Pre- or post-OP evaluation ☐ Suspected Multiple Sclerosis (not for CT) ☐ Follow up treatment (surgery/chemotherapy/radiation)	☐ Breakthrough seizures ☐ Vascular abnormalities (AVM Aneurysm Dissection Stenosis, Obstruction) ☐ Suspected acoustic neuroma ☐ Suspected pituitary adenoma and elevated prolactin (>20 ng/ml)
New Headache: ☐ With fever ☐ With exertion ☐ On awakening ☐ Focal neurological findings ☐ Worst headache of life (thunderclap)		
Chronic Headache: ☐ New neurological findings ☐ New syncope ☐ New mental status changes		
☐ CHEST		
☐ Chest wall or pleural mass ☐ Follow up trauma ☐ Significant Hemoptysis ☐ Persistent unexplained wheeze ☐ Lesion on chest x-ray suggestive of malignancy or metastatic disease ☐ Standard staging or post therapy follow-up for patient with a pathologically proven malignancy ☐ Congenital Heart Disease ☐ Acquired Pediatric Heart Disease	☐ Suspected vascular abnormality, aneurysm, AVM, congenital anomaly ☐ Suspected Pulmonary Embolus ☐ Persistent infiltrate/pneumonia despite 4–6 weeks antibiotic therapy ☐ Suspected/known asbestosis or other pneumoconiosis Chest x-ray results: ☐ Normal ☐ Abnormal ☐ Not performed in past 2 months	☐ Pre- or post-OP evaluation ☐ Mediastinal mass ☐ Screening for lung nodules ☐ Lung abscess or inflammatory process ☐ Chest x-ray or PFT suggestive of pulmonary fibrosis ☐ Signs or symptom suggestive of lung cancer (unintentional weight loss, anemia, paraneoplastic syndrome, etc.) ☐ Other (describe): _____
☐ SINUS, FACE, NECK, ORBIT		
☐ Follow up — Trauma ☐ Pre- or post-OP evaluation ☐ Painful swallowing ☐ Salivary gland mass or stone ☐ Staging of malignancy ☐ Suspected thyroid mass ☐ Known or suspected tumor (Palpable Neck Mass) ☐ Possible infection or abscess ☐ Vascular abnormalities (AVM Aneurysm Dissection Stenosis, Obstruction) ☐ Immunocompromised patient or fungal infection warranting MR		
☐ Sinusitis ☐ Acute (less than 3 months) ☐ Chronic (more than 3 months) ☐ Recurrent — (4 or more episodes/yr)	☐ Sinusitis Treatment ☐ No antibiotic treatment ☐ Failure single course antibiotics ☐ Failure 2 or more courses antibiotics	☐ Other (describe): _____ _____ _____
☐ UPPER/ LOWER EXTREMITIES		
☐ Recent trauma ☐ Palpable soft tissue mass ☐ Joint locking ☐ Joint infection/inflammation ☐ Avascular/Aseptic Necrosis ☐ Charcot joint ☐ Ligament, tendon, or fibrocartilage tear	☐ Pre- or post-OP evaluation ☐ Soft tissue abscess ☐ Tarsal coalition (feet) ☐ Requested as part of arthrogram ☐ Meniscal or labral tear ☐ Abnormal plain film, bone scan, or ultrasound ☐ Rotator cuff tear (shoulder)	☐ Known or suspected tumor, metastasis ☐ Fracture evaluation ☐ Suspected vascular abnormality (aneurysm dissection, thromboembolic disease, A-V malformation or fistula vasculitis, ischemia, pre or post op, venous thrombosis) ☐ Other (describe): _____
Upper/Lower Extremities X-Ray Results: ☐ Normal ☐ Abnormal ☐ Not performed ☐ Not performed in the past 2 months		
☐ PERSISTENT PAIN AND/OR DISABILITY (IF YES, CHECK REASON(S) BELOW)		
Prior Treatment (Check One) ☐ No prior treatment ☐ 3–5 weeks of treatment ☐ 6 or more weeks of treatment	Check all treatments that apply. ☐ NSAIDS ☐ Physical therapy ☐ Splinting/brace/sling ☐ Chiropractic treatment ☐ Home exercise program ☐ Oral/Intra-articular Steroids	
SECTION 6. DOCUMENT EXAM FINDINGS, PRIOR TESTS, RESULTS, AND DATES (INCLUDE TREATMENT DESCRIPTION FOR CONSERVATIVE THERAPY DURATION, PRIOR IMAGING, AND ANY TRAUMA HISTORY)		

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form.
 Providers may attach any additional data relevant to medical necessity criteria.