OUTPATIENT IMAGING PRIOR AUTHORIZATION REQUEST FORM

Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0844

Network Provider Pre-service Request - PAMA SCORE: _____________(scores ≥ 8 receive administrative approval)

DATE OF REQUEST: __________________ DATE OF PROCEDURE: ___

MEMBER NAME: ____ DOB: ________________

PARAMOUNT MEMBER ID: __________________________Paramount Secondary ID#:__________________
(if applicable)

ORDERING PHYS:______________________________ CONTACT NAME: ____________________

ORDERING PHYS NPI#:_________________________PHONE:_______________ FAX: __________________

FACILITY PERFORMING PROCEDURE: ____

FACILITY TAX ID#: _________________________________ NPI#: ________________________________

FACILITY ADDRESS: ____

FACILITY PHONE: ________________________________ BILLING OFFICE PHONE: ______________________

Solid Organ Transplant Request: ☐ Yes ☐ No

PLEASE COMPLETE STEPS 1 - 4

1. BODY PART TO BE TESTED:____
2. PLEASE CHECK TEST TO BE PERFORMED:
   - ☐ MRI SCAN – CPT: ____
   - ☐ MRA SCAN – CPT:____
   - ☐ CT SCAN – CPT: ____
   - ☐ CTA – CPT: ____
   - ☐ PET SCAN – CPT: ____
   - ☐ CARDIAC STRESS TEST CPT: ____
3. DIAGNOSIS: ____
4. ICD-10:____
5. MEDICAL/CLINICAL HISTORY (Clinical Notes Required For Review):

Current signs and symptoms:____

____

Results of any other pertinent diagnostic testing: ____

____

Consult or other treatment documentation supporting rationale for procedure: ____________________________

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