Atlantic Medical Imaging
72 West Jimmie Leeds Road, Suite 1100
Galloway, New Jersey 08205
Phone: 855-677-9729
Fax: 855-677-9783

ONCOLOGY AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION (PLEASE INCLUDE PATIENT DEMO SHEET, IF AVAILABLE)

Patient Name: _____ DOB: _____ /_____ /_____ Gender (Circle): M F

Address:_____

City:_____ State: _____ Zip Code: _____ Phone: _____-_____-_____

Insurance Company Name: _____ Policy ID #: _____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____

Fax #: _____

INS Provider / Tax ID#:_____

Reason for Exam: _____

Diagnosis, Staging, Re-staging, Suspected Recurrence, Surveillance

Diagnosis 1: _____ ICD10 Code 1: _____

Diagnosis 2:_____ ICD10 Code 2: _____

For new cancer diagnosis, please include type of cancer and date of diagnosis:_____

_____

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): (MANDATORY)

_____

_____

Findings from prior radiology exams: _____

Tissue diagnosis: ❑ Yes ❑ No

Rising Tumor Markers: ❑ Yes ❑ No If yes, please indicate which one(s) and value(s)_____

Chemotherapy (Start Date): _____ / _____ / _____ Chemotherapy (End Date): _____ / _____ / _____

Radiation (Start Date): _____ / _____ / _____ Radiation (End Date): _____ / _____ / _____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

❑ PET/CT

❑ Brain
❑ Cardiac
❑ Oncology (Skull - Mid Thigh)
Type of Cancer_____
❑ Melanoma (whole body)
❑ Other _____
CPT Code:_____

Isotope agent:
❑ FDG ❑ NaF

❑ CT

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen
❑ Chest, Thorax
❑ Head
❑ Neck
❑ Pelvis
❑ Other _____
CPT Code:_____

❑ MRI

❑ With & Without Contrast
❑ Without Contrast ❑ With Contrast

❑ Abdomen ❑ Neck
❑ Brain ❑ Pelvis
❑ Breast, Bilateral
❑ Chest, Thorax
❑ Head
❑ Other _____
CPT Code:_____

❑ Please notify me _____ days before authorization expiration.

Submitted by: _____ Phone #: _____ Date: _____ / _____ / _____

4 Fax completed forms to: 855-677-9783