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

Authorization Request Designation Form

[Ordering Physician] designates Atlantic Medical Imaging (AMI) to submit clinical authorization requests on his/her behalf. [Ordering Physician] agrees that when requesting that AMI submit a clinical authorization request for a patient, [Ordering Physician] shall furnish AMI complete and accurate documentation of the patient's diagnosis, clinical condition, test results, and treatment history in order to demonstrate medical necessity.

No Assurance of Authorization Approval
[Ordering Physician] understands that AMI makes no representation to [Ordering Physician] or assurances that the designation of AMI to submit clinical authorization requests hereunder shall result in approval of any preauthorization request. AMI shall have no liability to [Ordering Physician] or any patient for any failure to obtain an authorization.

Transparency of Call Center; Provision of Medical Record Documentation
[Ordering Physician] shall not provide AMI with its website login and password credentials. [Ordering Physician] understands that AMI representatives will identify themselves as representatives of AMI and will disclose the nature of the clinical authorization program. AMI will use its own login and password credentials when submitting [Ordering Physician's] clinical authorization requests via the Internet. For clinical authorization requests, [Ordering Physician] agrees to provide copies of patient information and medical records to AMI upon request and at no charge. [Ordering Physician] agrees to provide any reasonable documentation to AMI or the patient's health plan that may be required for an appeal of an adverse authorization decision.

Accurate Information; Compliance
[Ordering Physician] understands and acknowledges that any person furnishing materially false or misleading information to AMI in connection with a clinical authorization request may be subject to civil liability and/or criminal penalties and that in such event AMI may terminate, suspend or otherwise limit [Ordering Physician's] rights under this designation and advise the health plan of such action for its information and action. [Ordering Physician] shall comply with the Health Insurance Portability and Accountability Act of 1996, as amended [HIPAA] with respect to the transfer of patient information to, and maintenance of patient information by AMI.

By signing this designation, you will be agreeing to the above terms and conditions of the foregoing Designation Agreement. In so doing, you attest that you are the physician identified below OR that you are authorized to execute the foregoing Agreement on behalf of the Group identified below and that the Group is authorized to execute the foregoing Agreements on behalf of the physicians that are billed under the Group's TIN.

Physician Last Name: _____ First Name: _____ Middle Initial: ____

OR Group Name: _____

TIN: _____ Individual NPI: _____ or Organization NPI: _____

Address: _____

_____

Telephone: _____

Email: _____

Office Contact: _____

Date: ____ /____ /____

Preferred Method of Contact

❑ Fax: _____

❑ Secure Email

Fax completed forms to: (609) 653-8764

Atlantic Medical Imaging

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

Referring Group Clinician Roster

Group Name	First Name	Last Name	Degree	NPI

Fax completed forms to: (609) 653-8764

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (this "Agreement") is made as of the date set forth below on the signature page by and between the following parties (each a "Party" and collectively the "Parties"):

_____ with principal offices located at _____, New Jersey _____ ("Covered Entity")

and

Atlantic Medical Imaging, with principal offices located at 72 West Jimmie Leeds Road, Galloway, NJ 08205 ("Business Associate").

WITNESSETH:

WHEREAS, Business Associate has entered into an agreement with Covered Entity pursuant to which Covered Entity may disclose to Business Associate certain Protected Health Information (as defined below) concerning patients of Covered Entity (the "Services"); and

WHEREAS, Covered Entity and Business Associate intend to meet their obligations regarding the use and disclosure of Protected Health Information under the Health Insurance Portability and Accountability Act of 1996, Section 13400 et seq. of the Health Information Technology for Economic and Clinical Health Act and Section 105 of Title I of the Genetic Information Non-Discrimination Act of 2008, and the implementing regulations codified at 45 CFR Parts 160 and 164 (the foregoing statutes and regulations are referred to herein generally as "HIPAA").

NOW, THEREFORE, intending to be legally bound, the Parties hereto agree as follows:

1. **Entire Agreement.** This Agreement represents the entire agreement and understanding of the Parties with respect to the subject matter hereof, and it supersedes any prior or current oral or written business associate agreement between the Parties.

2. **Definitions.**

(a) Interpretation. The terms defined below are included for ease of reference and are intended to have the same meaning as provided under HIPAA. Other terms used but not otherwise defined in this Agreement are also intended to be defined and interpreted in accordance with HIPAA.

(b) "Breach." The term "Breach" means, as defined in 45 CFR § 164.402, the unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of such information.

(c) "Designated Record Set." The term "Designated Record Set" means, as defined in 45 CFR § 164.501, a group of records maintained by or for a covered entity that is, (i) the medical records and billing records about individuals maintained by or for a covered health care provider, or (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) used, in whole or in part, by or for Covered Entity to make decisions about individuals. For purposes of this paragraph, the term "record" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for Covered Entity.

(d) "Electronic Protected Health Information." The term "Electronic Protected Health Information" (also "E-PHI") means, as defined in 45 CFR § 160.103, individually identifiable health information that is transmitted by or maintained in electronic media.

(e) "Protected Health Information." The term "Protected Health Information" (also "PHI") means, as defined in 45 CFR § 160.103, information that, (i) is created or received by Covered Entity, (ii) relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual, and (iii) either identifies an individual or there is a reasonable basis to believe that it could be used to identify an individual.

(f) "Required by Law." The phrase "Required by Law" means, as defined in 45 CFR § 164.103, a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, a grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; civil or authorized investigative demands; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

(g) "Secretary." The term "Secretary" means, as defined in 45 CFR § 160.103, the Secretary of the Department of Health and Human Services or any other officer or employee of the department to whom the authority involved has been delegated.

(h) "Security Incident." The term "Security Incident" means, as defined in 45 CFR § 164.304, the attempted or successful unauthorized access, use, disclosure, modification or destruction of information, or interference with system operations in an information system.

(i) "Subcontractor." The term "Subcontractor" means, as defined in 45 CFR § 160.103, a person to whom Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of Business Associate.

(j) "Unsecured PHI." The term "Unsecured PHI" means, as defined in 45 CFR § 164.402, PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary.

3. **Permitted Uses and Disclosures of PHI.**

(a) Performance of Services. Except as otherwise prohibited or limited by any applicable law, rule or regulation, Business Associate may use or disclose PHI to perform the Services for or on behalf of Covered Entity, provided that (i) such use or disclosure involves only the minimum amount of PHI as is necessary for such performance, and (ii) the use or disclosure would not violate HIPAA if done by Covered Entity.

(b) Subcontractors. Business Associate may disclose PHI to a business associate (as defined in 45 CFR § 160.103) that is a Subcontractor and may permit such Subcontractor to create, receive, maintain or transmit PHI, including E-PHI, on its behalf, but only if Business Associate enters into a written business associate agreement with the Subcontractor that satisfies the requirements of 45 CFR § 164.314(a) and § 164.504(e).

(c) Management, Administration and Legal Responsibilities. Business Associate may use PHI as is necessary for the proper management and administration of Business Associate or for Business Associate to perform its legal obligations. Business Associate may disclose PHI for such purposes, but only if (i) the disclosure is Required by Law, or (ii) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any breach of confidentiality concerning such information of which it is aware.

(d) Data Aggregation Services. Except as otherwise set forth herein, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

(e) Reporting. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

4. **Responsibilities of the Parties with Respect to PHI.**

(a) Obligations and Activities of Business Associate.

(i) Business Associate shall not use or disclose PHI other than as permitted or required under this Agreement, or as Required by Law.

(ii) Business Associate shall use appropriate safeguards and comply with the applicable requirements of Subpart C of 45 CFR § 164 with respect to E-PHI to prevent the use or disclosure of PHI other than as provided for herein.

(iii) Business Associate shall comply with the applicable requirements of Subpart E of 45 CFR § 164. To the extent that Business Associate, in providing the Services, is carrying out one or more of Covered Entity's obligations under Subpart E of 45 CFR § 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligations.

(iv) Business Associate shall ensure that any Subcontractors that create, receive, maintain or transmit PHI, including any E-PHI, on behalf of Business Associate agree to comply with the applicable requirements of Subpart C and Subpart E of 45 CFR § 164, and that each Subcontractor enters into a business associate agreement with Business Associate under which each Subcontractor agrees to the same restrictions and conditions that apply to Business Associate with respect to PHI. In addition to other provisions required by HIPAA or this Agreement, such Subcontractor agreements shall contain provisions to ensure Business Associate will meet its reporting obligations under **Sections 4(a)(v)** and **4(a)(vi)**, immediately below.

(v) Business Associate shall promptly report to Covered Entity, within thirty (30) days of discovery, any use or disclosure of PHI not permitted by this Agreement, as well as any Security Incident. In addition, Business Associate shall promptly and without unreasonable delay, notify Covered Entity following the discovery of a Breach of Unsecured PHI as required by 45 CFR § 164.410, except that Business Associate shall make such reports to Covered Entity no later than thirty (30) days after discovery of the same unless a law enforcement official determines that such a report would impede a criminal investigation or cause damage to national security, in which case Business Associate will comply with 45 CFR § 164.412. A Breach is deemed discovered as of the first day on which it is known to Business Associate or to any person, other than the person committing the Breach, who is an employee, officer or other agent of Business Associate, or, by exercising reasonable diligence, would have been known to Business Associate or such person.

(vi) Business Associate shall include in any report required under **Section 4(a)(v)** immediately above, to the extent possible, (A) a description of the impermissible use/disclosure, Security Incident or Breach of Unsecured PHI, (B) the identification of each individual whose PHI has been, or is reasonably believed to have been, the subject of the impermissible use/disclosure, Security Incident or Breach of Unsecured PHI, and (C) such other available information, as requested by Covered Entity, which Covered Entity may be required to include in any required notifications to the affected individuals.

(vii) Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (A) a Security Incident, (B) a Breach of Unsecured PHI, and (C) a use or disclosure of PHI by Business Associate or its employees or agents, including any Subcontractors, in violation of the requirements of this Agreement. Further, Business Associate shall reasonably cooperate and coordinate with Covered Entity in the investigation of any violation of the requirements of this Agreement, including any impermissible use/disclosure, Security Incident or Breach of Unsecured PHI.

(viii) Business Associate, at the request of Covered Entity, shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524.

(ix) Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.

(x) Business Associate shall make available to Covered Entity information required to provide an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

(xi) Business Associate shall make internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary for purposes of the Secretary's determination of Covered Entity's compliance with HIPAA.

(b) Obligations of Covered Entity.

(i) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(ii) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(iii) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. **Term and Termination.**

(a) Term. This Agreement is effective as of the date first set forth below, and continues in effect until otherwise terminated in accordance with this **Section 5**.

(b) Termination.

(i) If either Party knows of a pattern of activity or practice of the other Party that constitutes a material breach or violation of this Agreement, then the Party shall provide written notice of the breach or violation to the other Party that specifies the nature of the breach or violation. The breaching Party must cure the breach or end the violation on or before thirty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to the non-breaching Party within the specified time frame, or in the event the breach is reasonably incapable of cure, then the non-breaching Party may do the following:

(A) if feasible, terminate this Agreement and any and all agreements for Services; or

(B) if termination of this Agreement or the agreements for Services is infeasible, report the issue to the Department of Health and Human Services.

(ii) Notwithstanding the foregoing, Covered Entity may immediately terminate this Agreement and any and all agreements for Services if Covered Entity determines that Business Associate has breached a material term of this Agreement and no cure is possible.

(c) Automatic Termination. This Agreement automatically terminates without any further action of the Parties, (i) if the Services are no longer provided by Business Associate to or on behalf of Covered Entity, or (ii) if HIPAA is no longer applicable to Covered Entity.

(d) Obligations of Business Associate upon Termination, Expiration or Non-Renewal.

(i) Return or Destruction. Upon the expiration, termination or non-renewal of this Agreement, for any reason, Business Associate shall return or destroy all PHI (including E-PHI) received from, or created or received by, Business Associate on behalf of Covered Entity that Business Associate still maintains in any form, and shall retain no copies of such PHI (including E-PHI), unless such return or destruction is not feasible.

(ii) Non-Return or Destruction. If it is not feasible for Business Associate to return or destroy the PHI (including E-PHI) upon the termination of this Agreement for any reason, as determined solely by Business Associate, Business Associate shall extend indefinitely any and all protections, limitations and restrictions contained in this Agreement to its use and disclosure of such PHI (including E-PHI).

6. **Miscellaneous.**

(a) Survival. The provisions of **Section 5(d)** survives the expiration or termination of this Agreement for any reason.

(b) Independent Contractor. Business Associate and Covered Entity are independent contractors. Nothing in this Agreement may be deemed or construed by the Parties hereto or by any third party as creating the relationship of employer and employee, principal and agent, partners, joint ventures, or any similar relationship, between the Parties.

(c) Amendments; Waiver. This Agreement may not be modified, nor may any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. A waiver with respect to one event may not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

(d) Counterparts; Facsimiles. This Agreement may be executed in any number of counterparts, each of which is deemed an original. Facsimiles hereof are deemed to be originals.

(e) Further Assurances. Each Party shall do all acts, and make, execute and deliver such written instruments as may from time to time be reasonably required to carry out the terms, conditions and provisions of HIPAA, as promulgated from time to time.

(f) Severability. If any provision of this Agreement or the application thereof to any person, entity, or circumstance is found, for any reason or to any extent, to be invalid or unenforceable by a court of competent jurisdiction or government agency with the authority to make such a finding, the remainder of this Agreement and the application hereof to any person,

entity or circumstance will not be affected thereby, but rather the remainder of this Agreement will be enforced to the greatest extent permitted by law.

(g) Choice of Law; Jurisdiction. This Agreement is governed by, and should be construed in accordance with, the laws of the State of New Jersey. The Parties consent to the filing of an action in, and hereby personally submit to the jurisdiction of, the state or federal courts located in the State of New Jersey.

(h) Benefit. This Agreement is binding upon and inures to the benefit of the Parties hereto, their respective heirs, executors, administrators, successors and permitted assigns.

(i) Assignment. Except as otherwise provided herein, this Agreement and the obligations, rights and benefits hereunder may not be assigned by either Party without the prior written consent of the other Party.

(j) Headings. The paragraph headings in this Agreement are solely for convenience or reference and are not intended to affect its interpretation.

(k) Notice. Whenever, under the provisions of this Agreement, notice is required to be given, it will be in writing and will be deemed given when mailed, certified or registered mail, return receipt requested, or delivered via nationally recognized overnight courier, addressed to the Parties at the addresses set forth above, or when given by hand delivery.

(l) Regulatory References. A reference in this Agreement to a section in HIPAA means the section as in effect or as amended.

(m) Construction. It is specifically understood and agreed by and between the Parties that this Agreement is the result of negotiations between the Parties. Accordingly, it is understood and agreed that all Parties will be deemed to have drawn these documents and there will be no negative inference from the language of this Agreement by any fact finders as against any Party.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf on the date set forth below.

COVERED ENTITY	**BUSINESS ASSOCIATE**
By:_____	By: 
Printed Name:_____	Printed Name: David Levi, MD
Title:_____	Title: President / CEO
Date:_____	Date: April 23, 2018

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

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#: _____

Diagnosis 1: _____ ICD10 Code 1: _____

Diagnosis 2: _____ ICD10 Code 2: _____

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

_____

_____

Findings from prior radiology exams: _____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

EXAM TYPE: ❑ MRI ❑ MRA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Brachial Plexus
❑ Brain
Hormone Levels
_____
❑ Breast, Bilateral
❑ Breast, Bilateral Implant Evaluation
❑ Breast, Bilateral Cancer Evaluation
❑ Chest
❑ MRCP
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
_____
Type of antibiotics
_____
Duration of antibiotics
_____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Ankle Rt ___ LT ___
❑ Elbow Rt ___ LT ___
❑ Foot Rt ___ LT ___
❑ Hand Rt ___ LT ___
❑ Hip Rt ___ LT ___
❑ Knee Rt ___ LT ___
❑ Shoulder Rt ___ LT ___
❑ Wrist Rt ___ LT ___
❑ Other CPT Code: _____

EXAM TYPE: ❑ CT ❑ CTA

❑ With & Without Contrast ❑ Without Contrast

❑ With Contrast

❑ Abdomen
❑ Abdomen/Pelvis
❑ Brain
❑ Carotid
❑ Chest
❑ Coronary CTA
❑ Head
❑ Heart
❑ Kidney
❑ Urography
❑ Neck
❑ Orbits
❑ Pelvis
❑ Pituitary
❑ Sinuses
Duration of symptoms
_____
Type of antibiotics
_____
Duration of antibiotics
_____
❑ C Spine
❑ L Spine
❑ T Spine
❑ Upper Extremity _____
❑ Lower Extremity _____
Date of Injury: ____/____/____
Date of onset of symptoms: ____/____/____
Date of PT start: ____/____/____
Medications: _____
❑ Other _____ CPT Code: _____
❑ With 3D Recons

❑ Please notify me _____ days before authorization expiration.

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

4 Fax completed forms to: 855-677-9783

Atlantic Medical Imaging
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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

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Phone: 855-677-9729
Fax: 855-677-9783

NUCLEAR MEDICINE 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#:_____

Diagnosis 1: _____ ICD10 Code 1:_____

Diagnosis 2:_____ ICD10 Code 2:_____

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

_____

_____

Findings from prior radiology exams: _____

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

NUCLEAR MEDICINE

- ❑ Biliary Ejection Fraction
- ❑ Biliary Scan
- ❑ Bone Scan 3 Phase
- ❑ Bone Scan Limited
- ❑ Bone Scan Total
- ❑ Gallium Scan
- ❑ Gastric Emptying Scan
  ❑ Liquid ❑ Solid
- ❑ Hepatobiliary Scan
- ❑ Hepatobiliary Scan with Ejection Fraction
- ❑ Liver/Spleen Scan
- ❑ Gated (MUGA/Cardiac Blood Pool)
- ❑ Parathyroid Scan
- ❑ Other _____
  CPT Code: _____
- ❑ Renal Pharmacological Intervention
  ❑ Lasix ❑ Captopril
- ❑ Salivary Gland Function
- ❑ Thyroid Uptake and Scan

- ❑ SPECT Bone
- ❑ SPECT Brain
- ❑ SPECT Liver
- ❑ SPECT Liver for Hemangioma
- ❑ SPECT Tumor Localization

❑ Please notify me _____ days before authorization expiration.

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

4 Fax completed forms to: 855-677-9783