CARE to CARE
MULTI-SPECIALTY MANAGEMENT

Imaging Excellence Program

Authorization Request Form
Fax this request form to 1-646-502-5043
Call in request to 1-347-670-1014
(Please print clearly)

Intermountain® Healthcare

Please consider using the web to submit your requests. To submit online, visit: https://hcpnv.careportal.com.

****If Urgent Please Call**

Referring Provider Information

#1 Date request submitted:	MM/DD/YYYY	#2 Office contact person:	
#3 Provider Name:		#4 Physician Specialty:	
#5 Physician ID (NPI):		#6 Phone: (XXX) XXX - XXXX	#7 Fax: (XXX) XXX - XXXX
#8 E-mail Address:			

Rendering Facility/Practice Information

#9 Facility/Practice Name:		#10 Facility/Practice Address:	
#11 Phone: (XXX) XXX - XXXX	#12 Fax: (XXX) XXX - XXXX	#13 Facility/Practice NPI#:	
#14 Member name:		#15 Date of Birth:	MM/DD/YYYY
#16 Member ID#:		#17 Member Phone #:	(XXX) XXX - XXXX

List procedure(s) Ordered

#18 Procedures	#19 CPT code	#20 Modifier	#21 Units

#22 Clinical indications for the ordered exams (e.g., signs, symptoms with severity and duration, working diagnosis)

THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY OF MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED.	#23 Primary ICD-10 Code

Any relevant prior tests, treatments or other information

If our Physician Reviewer needs to contact the ordering provider, what is the best day, time and phone number?

#24 Days (circle):	M T W Th F	#25 Times:		#26 Phone:	(XXX) XXX - XXXX
#27 Requested by (print):				#28 Submission Date:	MM/DD/YYYY

#29 Referring Provider Signature:

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Instructions for Filling out Form Fields of Required Information

Field No.	Name	**Description** – Below contains a brief description. For more detailed information see Provider Manual.
1.	*Date Request Submitted*	Date the Request form is being submitted **– MM/DD/YYYY**
2.	*Office Contact Person*	Person filling Prior Authorization Request Form or Name of Best Contact Person
3.	*Provider Name*	Referring/Ordering Provider's **First & Last Name**
4.	*Physician Specialty*	Referring/Ordering Provider's Specialty
5.	*Physician ID (NPI)*	Referring/Ordering Provider's NPI # **- Mandatory**
6.	*Phone*	Referring/Ordering Provider's Office Phone # **- 1 (XXX) XXX-XXXX**
7.	*Fax*	Referring/Ordering Provider's Office Fax # **- 1 (XXX) XXX-XXXX**
8.	*E-Mail Address*	Referring/Ordering Provider's Office E-Mail Address **- Mandatory**
9.	*Facility/Practice Name*	Rendering Facility/Practice Name Where Procedure Will Take Place
10.	*Facility/Practice Address*	Rendering Facility/Practice Address Where Procedure Will Take Place
11.	*Phone*	Rendering Facility/Practice Phone # **- 1 (XXX) XXX-XXXX**
12.	*Fax*	Rendering Facility/Practice Fax # **- 1 (XXX) XXX-XXXX**
13.	*Facility/Practice NPI #*	Insert Rendering Facility/Practice NPI#
14.	*Member Name*	Name of Member Procedure is Being Requested For
15.	*Date of Birth*	Date of Birth for the Member **– MM/DD/YYYY**
16.	*Member ID #*	Medicaid ID # of the Member
17.	*Member Phone #*	Best Contact Phone # for the Member **- 1 (XXX) XXX-XXXX**
18.	*Procedures*	Description or Modality of Procedure(s) Being Requested
19.	*CPT Code*	CPT Code Associated with Requested Procedure(s)
20.	*Modifier*	Body Modifier (i.e. Left, Right)
21.	*Units*	Number of Requested Units
22.	*Clinical Indications for the Ordered Exams*	Explained in Description, Option to Fill In Information Fields or Attach Clinical Notes
23.	*Primary ICD-10 Code*	Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code
24.	*Days (Circle)*	Best Day(s) Available to Reach Referring Physician **– circle days**
25.	*Times*	Best Time(s) of Day to Reach Referring Physician **– (Note Program Open 8am-5pm PST)**
26.	*Phone*	Best Phone # to Reach Referring Physician **- 1 (XXX) XXX-XXXX**
27.	*Requested by (Print)*	Printed Name of Referring/Ordering Provider
28.	*Submission Date*	Date the Prior Authorization Form is Being Submitted
29.	*Signature*	Signature of Ordering Provider

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