CARE to CARE
MULTI-SPECIALTY MANAGEMENT

Imaging Excellence Program

Authorization Request Form

Fax this request form to 1-888-925-7816

(Please print clearly)

HealthTradition Health Plan
WITH MAYO CLINIC HEALTH SYSTEM

STOP **Please consider using the web to submit your requests. To submit online, visit: https://hthp.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	
Rendering Facility/Practice Information					
#8 **Facility/Practice Name:**		#9 **Facility/Practice Address:**			
#10 **Phone:** (XXX) XXX - XXXX		#11 **Fax:** (XXX) XXX - XXXX		#12 **Facility/Practice NPI#:**	
#13 **Member name:**		#14 **Date of Birth:**	MM/DD/YYYY		
#15 **Member ID#:**		#16 **Member Phone #:**	(XXX) XXX - XXXX		

List procedure(s) Ordered

#17 **Procedures**	#18 **CPT code**	#19 **Modifier**	#20 **Units**

#21 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.	#22 **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?

#23 **Days** (circle):	M T W Th F	#24 **Times:**		#25 **Phone:**	(XXX) XXX - XXXX
#26 **Requested by (print):**				#27 **Submission Date:**	MM/DD/YYYY
#28 **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.	*Facility/Practice Name*	Rendering Facility/Practice Name Where Procedure Will Take Place
9.	*Facility/Practice Address*	Rendering Facility/Practice Address Where Procedure Will Take Place
10.	*Phone*	Rendering Facility/Practice Phone # - 1 (XXX) XXX-XXXX
11.	*Fax*	Rendering Facility/Practice Fax # - 1 (XXX) XXX-XXXX
12.	*Facility/Practice NPI #*	Insert Rendering Facility/Practice NPI#
13.	*Member Name*	Name of Member Procedure is Being Requested for
14.	*Date of Birth*	Date of Birth for the Member **–** MM/DD/YYYY
15.	*Member ID #*	Medicaid ID # of the Member
16.	*Member Phone #*	Best Contact Phone # for the Member - 1 (XXX) XXX-XXXX
17.	*Procedures*	Description or Modality of Procedure(s) Being Requested
18.	*CPT Code*	CPT Code Associated with Requested Procedure(s)
19.	*Modifier*	Body Modifier (i.e. Left, Right)
20.	*Units*	Number of Requested Units
21.	*Clinical Indications for the Ordered Exams*	Explained in Description, Option to Fill in Information Fields or Attach Clinical Notes
22.	*Primary ICD-9 Code*	Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code
23.	*Days (Circle)*	Best Day(s) Available to Reach Referring Physician **–** circle days
24.	*Times*	Best Time(s) of Day to Reach Referring Physician **–** (Note Program Open 7am-5pm CST)
25.	*Phone*	Best Phone # to Reach Referring Physician - 1 (XXX) XXX-XXXX
26.	*Requested by (Print)*	Printed Name of Referring/Ordering Provider
27.	*Submission Date*	Date the Prior Authorization Form is Being Submitted
28.	*Signature*	Signature of Ordering Provider

Revised 09/2016

Think GREEN **Please use the web for your requests. To submit online, visit: https://hthp.careportal.com.**