CARE to CARE
MULTI-SPECIALTY MANAGEMENT

Imaging Excellence Program

Authorization Request Form

Fax this request form to 1-888-495-9292

(Please print clearly)

NEW WEST
MEDICARE

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

#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:**					

This fax contains privileged and confidential information intended only for the use of the specific individual or entity named above. If you or your employer is not the intended recipient of this facsimile (or agent responsible for delivering it to the intended recipient), you are hereby notified that any unauthorized distribution or copying of this facsimile or the information contained in it is strictly prohibited. If you have received this facsimile in error, please notify the person named above by phone and return the original facsimile to the above address via the U.S. Postal Service.

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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 8am-7pm EST)**
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

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