PREAUTHORIZATION FAX FORM

If Urgent request please call Anthem @888-730-2817

Instructions:

Please complete ALL information requested on this form, incomplete forms will be returned to sender.

TO: Anthem UM Services, Inc. www.anthem.com

FAX #: 888-730-2831

FROM: Contact Person	Phone #:	
	Fax #:	

Subscriber (Insurance Holder) and Patient Information

Subscriber Name:

Last:________________________ **First:**_______________

ID #: (include alpha prefix)______________________________

SSN:_______________________________________

Health Plan Name: _________________________________

Group #:______________ Product type: ☐PPO ☐POS ☐HMO ☐Other: ____________

Patient Name:

Last :______________________________**First:**________________

DOB:______/_________/___________ **SEX: M F**

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD

Referring Physician Information
(The physician who is ordering the exam)

Name:

Last:____________________ **FIrst:**_____________________

Phone: ___________________________________

Fax: _____________________________________

Address: ____

Specialty:__DPM__________

Provider Information
(Where the service will be provided)

Name of Facility:__Extremity Imaging Partners__

Address: ____

Phone: (__866_______)__398-7364___

TIN # 04-3627188 **PROVIDER ID** 000000340701 **IN NTWK**

Procedure(s) Information (please include CPT Code, if available)

Procedure Code for Billing

Date of Procedure: _____/________/______	**Procedure: MRI Lower extremity w/o contrast**__________________	**CPT Code:** __________
Date of Procedure: ______/_______/_______	**Procedure:** ____	**CPT Code:** __________
Date of Procedure: ______/_______/_______	**Procedure:** ____	**CPT Code:** __________

Clinical Information *(all info must be completed)*

1. Patient's diagnosis or symptoms (include duration, frequency, and intensity)____
____
____

2. What is the physician suspecting or ruling out with the requested study?
____
____

3. Has the patient received treatment for the above symptoms (include duration and type)?
____
____

4. List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), include results:____________________
____

5. Is this injury related? ☐ Yes ☐ No Date and type of Injury: ______________________________________

6. Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis? ☐ Yes ☐ No

Cancer type:_________________________________