



## BUCKEYE OUTPATIENT IMAGING PRIOR AUTHORIZATION FAX REQUEST FORM

DATE OF REQUEST:	/ /	DATE OF PROCEDURE:	/ /
MEMBER NAME:		DOB:	
BUCKEYE MEMBER ID NUMBER:		ORDERING PHYSICIAN:	ORDERING PHYSICIAN PROV ID:
CONTACT NAME:		PHONE: ( )	FAX: ( )
FACILITY PERFORMING PROCEDURE:			CITY:

### PLEASE COMPLETE STEPS 1-4

<b>1. BODY PART TO BE TESTED:</b>	
<b>2. PLEASE CHECK TEST TO BE PERFORMED:</b>	
MRI SCAN <b>with</b> contrast	CPT:
MRI SCAN <b>without</b> contrast	CPT:
MRA SCAN <b>with</b> contrast	CPT:
MRA SCAN <b>without</b> contrast	CPT:
PET SCAN	CPT:
PET/CT SCAN	CPT:
CT SCAN <b>with</b> contrast	CPT:
CT SCAN <b>without</b> contrast	CPT:
NUCLEAR CARDIOLOGY (ENTER TEST TYPE)	CPT:

<b>3. DIAGNOSIS</b>	
a.	Patient's diagnosis or symptoms (include duration, frequency & intensity):
b.	What is the physician suspecting or ruling out with the requested study?
c.	Has the patient received treatment for the above systems (including duration and type)?
d.	When was the last similar MRI/CT/PET scan done?
e.	List any previous relevant testing (i.e., labs, diagnostic imaging or other test), <b>include results:</b>
f.	<b>Is this injury related?</b> YES or NO <b>Date and type of injury:</b>
g.	Is study part of a standard post-chemo / radiation protocol in a patient with a prior cancer diagnosis? YES or NO
	Cancer Type:

<b>4. PLEASE FAX THIS FORM AND THE FOLLOWING INFO TO BUCKEYE'S PRIOR AUTH DEPARTMENT. SW REGION: 866-529-0291; EC REGION: 866-535-4083; NE REGION: 866-529-0290; NW REGION: 866-535-4084.</b>	
▶	Medical / clinical history
▶	Current signs and symptoms
▶	Results of any other pertinent diagnostic testing
▶	Consult or other treatment documentation supporting rationale for procedure

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<b>Protected Health Information</b>
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