Radiology Prior Authorization Request Form

Date______________________________

Number of Pages______________________

Fax______________________________

Patient Name ____________________ DOB____________________

Subscriber ID ____________________ Group Number____________________

Referring Physician ____________________ Physician TAX ID# ____________________

Physician Address ____

City ____________________ State__________ ZIP Code __________

Physician Fax Number____

Physician Phone Number ____

Contact Name ____

Requested CPT/Exam____________________ ICD9____________________

1 What is the working diagnosis? ____________________ Rule out ____________________

Symptoms/Complaints:

Symptoms and Complaints	Duration

Findings on physical exam (include provocative tests if applicable):

Subscriber ID ______________________________
Group Number ______________________________

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Office visit and the physical exam findings

Physical Exam Findings	Date	Results

Results of pertinent recent lab tests relevant to the current problem:

Test	Date	Results

Medications used for the current problem:

Medication	Duration and Dates	Effective Yes/No

Treatment	Date	Effective Yes/No

2 Is there other history or clinical facts supporting this requested examination? Use additional sheets if necessary.______________________________

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Physician's Signature ______________________________ Date ______________

Use additional sheets if necessary. To be accepted, this document must be signed by the ordering physician.

Please fax this form, along with any additional documentation, to UnitedHealthcare at **1-866-889-8061**.

Please call **1-866-889-8054** if you have any questions.

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