4YOURCHOICENETWORK

RADIOLOGY PRIOR AUTHORIZATION FORM

RadNet Phone: (310) 445-2911

RadNet Fax: (844) 841-4324

Level of Urgency to be Processed: ☐ **URGENT 24 Hours** ☐ **ROUTINE 72 Hours**

Request Date: ______________________

Patient Name: ______________________ **DOB**: ______________________

Patient Address: ______________________ Phone: ______________________

City: ______________________ Zip Code: ______________________

Health Plan: ______________________ **Social Security:** ______________________

Referring Physician (Print): ______________________ **Specialty**: ______________ PCP (Print): ______________________
(If Different from Referring Physician)

Diagnosis: ______________________ ☐ Iodine Allergy ☐ Pacemaker

Procedure Requested: ______________________ ______________________

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Description/Pertinent Clinical Information: ______________________

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☐ **TO EXPEDITE PROCESS - PLEASE ATTACH CLINICAL DOCUMENTATION/LABORATORY/IMAGING/CONSULTS**

☐ Pertinent Labs Included ______________________ ☐Pertinent Radiology Exams Included ______________________

☐ Clinical Notes Included ______________________ ☐ Consult Included by Dr. ______________________

AVAILABLE IMAGING FACILITIES (Please Indicate Choice)

☐ Rancho Mirage ☐ Palm Desert ☐ Palm Springs

Physician Signature:______________________ **Phone: (   )**______________________**Fax: (   )**______________________

Total No. Pages Included in Fax: ____________