Subject: Pre-Authorization Service for High-Tech Radiology Services

Diagnostic Imaging Associates has implemented a "Pilot Program" for Pre-Authorization Service for our Referring Provider Community. This program applies to computerized tomography (CT), computed tomography angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and nuclear cardiac imaging studies.

Please note: We are not able to do stat requests due to the nature of the questions asked. They are best handled with the patient's full chart and referring doctor at hand.

If your patient needs services that require preauthorization/notification, complete our preauthorization request form and fax it to us at (302) 292-0204 along with the clinical information necessary to complete the request. **Keep in mind that all clinical information should be completed on our form clearly and concisely.** Our Diagnostic Imaging Pre-Authorization Representative will:

- Verify eligibility and benefits
- Obtain authorization
- Schedule procedure at any of our DIA locations

If additional information is required or the form is not complete we will contact you for the necessary information. Note; It may also be necessary to contact you for your assistance in interpreting some of the physicians notes.

Your office will be provided with the authorization number as well as your patient's scheduled appointment date, time, and location.

You will need to register for the Pre-Authorization Service by faxing the completed registration form to us at (302) 292-0204 and by providing your Marketing Representative with the original signed registration form.

Please contact our Pre-Authorization Service Specialist Michelle Connor at (302) 451-5667 or via email mconnor@diaxray.com. You may also contact Kathie Giordano, Mgr. at (302) 451-5664 or via email kgiordano@diaxray.com for any questions you may have regarding authorization.

PRE-AUTHORIZATION SERVICE REGISTRATION FORM

Referring Physician Practice Name: _____

Physician Specialty:_____

Individual Referring Physician's Information:

Name:_____

Tax ID #_____

NPI #_____

Referring Physician's Address:

Street:_____

Suite:_____

City, State, Zip:_____

Phone Number:_____

Fax Number:_____

Contact Person Information:

Name:_____

Phone Number: _____

Email Address:_____

I, _____, give Diagnostic Imaging Associates permission to obtain authorizations for our patients on their behalf and agree to provide medical records as needed to complete all requests. I would like to receive my confirmation by: Fax _____Email ____.

To receive pre-authorization assistance, please fax the DIA pre-authorization request form to Michelle Connor at (302) 292-0204. For more information about this service you can contact Michelle at (302) 451-5667 or via email mconnor@diaxray.com. You may also contact Kathie Giordano, Mgr. at (302) 451-5664 or via email kgiordano@diaxray.com.

Once authorization has been obtained, we will contact the patient to schedule their appointment. We will also contact your office with the patient's authorization number as well as their schedule appointment date and time.

Signature: _____ **Date:** _____

REQUEST FOR PRE-AUTHORIZATION
PLEASE PRINT CLEARLY

Phone (302) 451-5667
Fax: (302) 292-0204

Date of Request _____

Physician's First Name_____**Physician's Last Name** _____

Patient Name (Last Name, First Name, Middle Initial) **DOB** **Sex M { } F { }**

_____ ___/__/___

Address _____

Daytime Phone#_____ **Insured's Name**_____

Insured's ID#_____ **Group#**_____ **Health Plan**_____

Other Health Plan_____ **Injury/Worker's Comp**_____

PLEASE ATTACH CLINICAL NOTES & PRESCRIPTION

Service Requested_____

Symptoms requiring service_____

Previous Medication Therapy/Physical Therapy/Imaging Studies_____

_____

DIA Site Preference_____

CPT Code(s) _____

Diagnosis/ICD.9 Code(s) _____; _____; _____; _____; _____

Onset of symptoms (date) ____/____/____

Completed by_____

Comments_____

FOR DIAGNOSTIC IMAGING USE ONLY:

Insurance Co Contact Name_____

Authorization#_____ **Status**_____

Effective_____ **Expires**_____

Authorized Facility_____

Scheduled Yes { } No { } **Date of Appt** _____ **Appt. Time** _____

Comments_____