CALL NIA FOR AUTHORIZATION—1-888-203-1423

Subscriber (Insurance Holder) and Patient Information

Subscriber	Patient
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)***	***Provider Information*** ***(Where the service will be provided)***
Name: **Last:**____________________________**First:**________________ **Phone:** (___________)_____________________________________ **Fax:** (___________)_______________________________________ **Address:** ____ **Specialty:**____	See provider table below

Name of Facility	**Extremity Imaging Partners**
Tax ID	**04-3627188**
Address	
City, State, Zip	
Phone	**(866) 398-7364**

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

Date of Procedure: ______/_______/_______ **Procedure:** ____ **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:__________________________________