Advanced Imaging Prior Authorization Request Form

Fax completed form to 1.888.931.2468
(Please print clearly)

Attention

Providers may submit radiology prior authorization requests online, saving time and paper, and providing better traceability of submitted requests. To submit this request online, please go to www.ct.gov/husky, click "For Providers," then select the "Access the CAREPortal" button.

For dates of service beginning July 1, 2016, prior authorization will no longer be required for:
Advanced Imaging Services for members ages 18 and under, as of date of service
and Nuclear Cardiology Services for members of all ages.

If urgent please call 1.800.440.5071. Select Option "2" for Medical Authorizations, then Option "1" for Radiology Authorizations.

Referring Provider Information

#1 Date Request Submitted:		#2 Office Contact Person:	
#3 Provider Name:		#4 Physician Medicaid (CMAP) ID#:	
#5 Physician ID (NPI):		#6 Phone:	#7 Fax:

Rendering Facility/Practice Information

#8 Facility/Practice Name:		#9 Facility/Practice Address:	
#10 Phone:		#11 Fax:	#12 Facility/Practice Medicaid (CMAP) ID#:

#13 Member Name:		#14 Date of Birth:	
#15 Member ID#:		#16 Member Phone #:	
#17 Program: (check one)	HUSKY: ☐A ☐B ☐C ☐D or ☐Limited Benefits Group		

List Procedure(s) Ordered

#18 Procedures	#19 CPT code	#20 Modifier	#21 Units

#22 Clinical indications for the ordered exams (e.g., signs, symptoms with severity and duration, working diagnosis)

THIS SECTION MAY BE ACCOMPANIED OR REPLACED BY A COPY OF MEDICAL NOTES AND/OR REPORTS OF RELEVANT IMAGING AND LAB STUDIES SUPPORTING THE MEDICAL NECESSITY FOR THE STUDY REQUESTED.	#23 Primary ICD-10 Code

Any relevant prior tests, treatments or other information

If our Physician Reviewer needs to contact the ordering provider, what is the best day, time and phone number?

#24 Days (check):	☐M ☐T ☐W ☐Th ☐F	#25 Times:		#26 Phone:	
#27 Requested by (print):					

#28 Referring Provider Signature:

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Instructions for Filling out Form Fields of Required Information

Field No.	Name	**Description** – Below contains a brief description. For more detailed information see Provider Manual.
1.	*Date Request Submitted*	Date the Request form is being submitted **–** **MM/DD/YYYY**
2.	*Office Contact Person*	Person filling out Prior Auth Form or Name of Best Contact Person
3.	*Provider Name*	Referring/Ordering Provider's **First & Last Name**
4.	*Physician Medicaid (CMAP) ID #*	Insert Referring/Ordering Provider's Medicaid (CMAP/AVRS) ID – **Mandatory**
5.	*Physician ID (NPI)*	Referring/Ordering Provider's NPI **#** - **Mandatory**
6.	*Phone*	Referring/Ordering Provider's Office Phone **# -** **1 (XXX) XXX-XXXX**
7.	*Fax*	Referring/Ordering Provider's Office Fax **# -** **1 (XXX) XXX-XXXX**
8.	*Facility/Practice Name*	Rendering Facility/Practice Name Where Procedure Will Take Place
9.	*Facility/Practice Address*	Rendering Facility/Practice Address Where Procedure Will Take Place
10.	*Phone*	Rendering Facility/Practice Phone # **-** **1 (XXX) XXX-XXXX**
11.	*Fax*	Rendering Facility/Practice Fax # **-** **1 (XXX) XXX-XXXX**
12.	*Facility/Practice Medicaid (CMAP) ID #*	Insert Rendering Facility/Practice Medicaid (CMAP/AVRS) ID – **Optional, Provide if available**
13.	*Member Name*	Name of Member Procedure is Being Requested For
14.	*Date of Birth*	Date of Birth for the Member **–** **MM/DD/YYYY**
15.	*Member ID #*	Medicaid ID # of the Member
16.	*Member Phone #*	Best Contact Phone # for the Member **-** **1 (XXX) XXX-XXXX**
17.	*Program (check one)*	Program under which Member is covered **(Please select ONE box)**
18.	*Procedures*	Description or Modality of Procedure(s) Being Requested
19.	*CPT Code*	CPT Code Associated with Requested Procedure(s)
20.	*Modifier*	Body Modifier (i.e. Left, Right)
21.	*Units*	Number of Requested Units
22.	*Clinical Indications for the Ordered Exams*	Explained in Description, Option to Fill In Information Fields or Attach Clinical Notes
23.	*Primary ICD-10 Code*	Minimum of 1 Primary Diagnosis/ICD-10 Code Required with Each Requested CPT Code
24.	*Days (Check)*	Best Day(s) Available to Reach Referring Physician **–** **check days**
25.	*Times*	Best Time(s) of Day to Reach Referring Physician **–** **(Note Program Open 8am-7pm)**
26.	*Phone*	Best Phone # to Reach Referring Physician **- 1 (XXX) XXX-XXXX**
27.	*Requested by (Print)*	Printed Name of Referring/Ordering Provider
28.	*Signature*	Signature of Ordering Provider

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