Authorization Request
Advanced Radiology

To initiate the review process, complete this form, attach any additional relevant clinical information, and fax it using a secure cover sheet to **1-888-285-6851.** HealthHelp® representatives and clinicians are available Monday-Friday, 7:00 AM to 7:00 PM CST and Saturday, 7:00 AM to 4:00 PM CST.

Expedited: Medically necessary request that requires IMMEDIATE HANDLING due to an unforeseen illness, injury, or condition that could impact the patient's condition. An urgent request may be faxed to: **1-877-391-7292.** Please ensure that legible contact information is included for the ordering physician and/or his/her designee stating how they may be reached within the next 24 hours in case additional clinical information is needed to complete the review.
☐By checking this box, the Ordering Physician believes that waiting for a decision under standard time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy, therefore, the request should be treated as Expedited.

Date of Request:		Time:
Contact Name:		Contact Phone:
PATIENT INFORMATION		
Patient Name:		
Patient ID:		Patient Date of Birth:
ORDERING PHYSICIAN INFORMATION		
Ordering Physician Name:		Ordering Physician NPI:
Name & Address of Ordering Facility:		
Phone:		Fax:
RENDERING FACILITY INFORMATION		
Name of Rendering Facility:		Tax ID:
Facility Address:		
Phone:	Fax:	Date of Service:
Treatment Location (circle one): Physician Office Outpatient Facility Hospital Inpatient		If inpatient, length of stay:
TREATMENT/PROCEDURE INFORMATION		
Diagnosis Code (ICD-10):		
Procedure Requested (Procedure Code):		
CLINICAL INFORMATION PERTINENT TO THE TREATMENT IN QUESTION		
Prior Symptoms:		
Prior Imaging Studies and Results:		
Prior Laboratory Studies and Results:		