

**Request for Pre-Authorization
Advanced Imaging-CT/MRI/PET**



Date of request: _____

Member Name: _____

Member ID#: _____

Medicaid# _____ DOB _____

SEND THRU *PORTAL* OR FAX TO 877-267-7900

5 business days Advanced Notice is Required

Requesting Provider: _____

Provider ID#: _____

Contact _____

Phone: _____

FAX: _____

Date of request: _____

Place of Service: _____

Phone: _____

Fax: _____

Diagnosis: _____

Diagnosis Codes: _____

	Type/Body Part	Procedure Codes		
<input type="checkbox"/> CT/CTA	_____	_____	_____	_____
<input type="checkbox"/> MRI/MRA	_____	_____	_____	_____
<input type="checkbox"/> PET	_____	_____	_____	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____

SEE IMAGING INDICATIONS/CRITERIA AT: WWW.SUFFOLKHEALTHPLAN.COM/IQCRITERIA.HTML

Chief complaint/HPI: _____

Physical findings/test results: _____

Treatment/duration/results: _____

√ For questions about the pre-authorization process please call Care Coordination at 800-765-3805

√ You can go to our [provider web portal](http://www.suffolkhealthplan.com) at www.suffolkhealthplan.com to check the status of the

√ authorization within 2 business days

Care Coordination will fax an authorization letter to you when your request has been completed. If the service(s) is not approved a Care Coordinator will call you with the determination by telephone and in writing