QUALITY CARE PARTNERS

Phone: 740-455-5199

Authorization Request: CT Scan

Please Fax Request to: (740) 455-8817

Today's Date: _____

Member Information

Member Name: _____DOB: _____

Member ID#: _____ Employer: _____

Ordering Physician Information

Physician Name: _____Phone/Fax #: _____/_____

Physician Address: _____

Physician Tax ID/NPI: _____ Office Contact Person: _____

Facility Information

Facility Name: _____ Facility Tax ID/NPI: _____

Facility Address: _____ Phone/Fax #: _____

Diagnosis: _____

Diagnosis Code(s): _____

CPT Code(s): _____

Date of Service: _____

Reason for Imaging: _____

_____

Date of Most Recent Exam: _____

Exam Findings: (print legibly or attach office notes) _____

_____

_____

Other Imaging/ Testing: _____

_____