



Preauthorization for Imaging Studies

Call (716) 857-6303 or 1 (888) 576-7783 or Fax (716) 857-6361 or 1 (888) 465-1373

The imaging studies listed on this form require preauthorization.

Ordering physicians must follow these procedures to obtain preauthorization prior to scheduling a study.

- Complete this form and fax it, or call in the information, at the numbers provided.

- If the requested procedure meets the criteria for medical necessity, the Health Plan will assign it a preauthorization number.

- Provide that number to the radiology facility when scheduling the study.

Authorizations are valid for 60 days following the date of approval.

Payment of claims is subject to eligibility on the date of service and to contractual limitations, provisions, and exclusions.

Emergent and in-patient procedures do not require pre-authorization. Urgent after-hours procedures should be called in to (716) 857-6303 or 1 (888) 576-7783 the next business day.

Date of Request:		Expedite? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reference No:		For Univera Use Only	
Patient / Member Information							
Last Name :				First Name:			
ID Number:			DOB:		Home Phone:		
REQUIRED:		(Check One) <input type="checkbox"/> COB <input type="checkbox"/> No-Fault <input type="checkbox"/> WC <input type="checkbox"/> N/A			Date of Injury:		
Ordering Physician Information							
Physician Name:				Prov. ID#:			
Physician Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist				Phone:			
Office Contact:				Fax:			
Facility and Procedure Information							
Name of Radiology Facility:							
Diagnosis:				ICD9 Code:			
Clinical Review							
Imaging Study Requested				Additional Information			
CT	<input type="checkbox"/> Orbit			Clinical Indications for Requested Study:			
	<input type="checkbox"/> Sinus						
	<input type="checkbox"/> Cervical Spine			Patient Symptoms and Duration:			
	<input type="checkbox"/> Thoracic Spine						
	<input type="checkbox"/> Lumbar Spine						
<input type="checkbox"/> Lower Extremity							
MRI	<input type="checkbox"/> Cervical Spine			Clinical Findings Based on Physical Exam, Lab Pathology:			
	<input type="checkbox"/> Thoracic Spine						
	<input type="checkbox"/> Lumbar Spine			Results of Previous Imaging Studies for Present Condition:			
	<input type="checkbox"/> Lower Extremity						
	<input type="checkbox"/> Lower Extremity, Joint						
<input type="checkbox"/> TMJ							
MRA	<input type="checkbox"/> Spine			What conservative therapy was attempted prior to requesting study?			
	<input type="checkbox"/> Abdomen						
	<input type="checkbox"/> Neck						
	<input type="checkbox"/> Upper Extremity						
	<input type="checkbox"/> Lower Extremity						
	<input type="checkbox"/> Chest			Other pertinent information:			
	<input type="checkbox"/> Pelvis						
<input type="checkbox"/> Head							
PET	<input type="checkbox"/> Brain						
	<input type="checkbox"/> Body/Lung						
	<input type="checkbox"/> Cardiac, RUB						
	<input type="checkbox"/> Cardiac, FDG						

