



Authorization Request Form - Part 2

Diagnostic imaging

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

 Please fill in each question option completely → ●

Patient Information	First name	Last name
	Member ID	Date of birth (MM/DD/YYYY)

Question 1	<p>By continuing with this request, the provider is attesting that this request is medically reasonable and appropriate</p> <p><input type="radio"/> Yes, the provider is attesting that this request is medically reasonable and appropriate</p>
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