

# PRIOR AUTHORIZATION / REFERRAL FOR IMAGING

**IMPORTANT!**

Illegible/Incomplete requests will be sent back for clarification and completion. All requests for authorization must be complete and include all information necessary to make medical necessity decisions in a timely manner.

FAX FORM(S) TO: SAMARITAN UTILIZATION MANAGEMENT  
(541) 768-4211 or (541) 768-4212

For SHPO Internal Use Only:

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For assistance with completing this form, please call: (541) 768-5207 or 1-888-435-2396

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|--|--|---|
| <input type="checkbox"/> Standard <input type="checkbox"/> Expedited <input type="checkbox"/> Retro request  | Date:  |   |
| Medical documentation <b>required</b> if referral is to be <b>EXPEDITED</b><br>MD Sign*: _____   | <i>*Signature indicates waiting for a decision within standard timeframe could place member's life, health, or ability to regain maximum function in serious jeopardy.</i> |   |
| <b>CHECK HEALTH PLAN:</b>  |  |   |
| <input type="checkbox"/> IHN <input type="checkbox"/> COHO <input type="checkbox"/> Samaritan Advantage <input type="checkbox"/> Samaritan Choice <input type="checkbox"/> Samaritan Healthy KidsConnect |  |   |
| <b>PATIENT INFORMATION:</b>  |  |   |
| Last Name:   | First Name: _____ MI: _____  |   |
| Patient's Primary Care Provider:   | Date of Birth: ____ / ____ / ____    Health Plan ID #: _____   |   |
| <b>PRIOR AUTHORIZATION / REFERRAL:</b>   |  |   |
| ICD-9 Code:  | CPT/HCPC Code:   | Date of Scheduled Appointment: ____ / ____ / ____<br><input type="checkbox"/> To Be Scheduled |
| Requesting Provider Name (First, Last):  |  | PAR Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No                        |
| Address:   | Phone:   | Fax:  |
| Contact Person:  | Phone:   | Fax:  |
| <b>REFERRAL TYPE:</b>  |  |   |
| <input type="checkbox"/> MRI <input type="checkbox"/> MRA <input type="checkbox"/> CAT Scan <input type="checkbox"/> PET Scan <input type="checkbox"/> SPCT  | Body Part: _____   |   |
| Hospital / Facility:   | Phone:   | Fax:  |
| <b>REASON FOR ADVANCED IMAGING: (must complete Imaging PA page 2, if applicable)</b>   |  |   |
|  |  |   |
| <b>OTHER TESTS PERFORMED / TREATMENT GIVEN &amp; DURATION:</b>   |  |   |
|  |  |   |
| <b>HOW WILL RESULTS AFFECT TREATMENT PLAN:</b>   |  |   |
|  |  |   |

**REMINDER: Form must be complete and must include supporting documentation.**