



<b>PRE-AUTHORIZATION FORM</b>	10840 Little Patuxent Pkwy	1030 N. Charles St
	Suite 202 Columbia MD 21044	Baltimore MD 21201

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell/Work: \_\_\_\_\_  
**Primary Insurance:** \_\_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**EXAM INFORMATION**

**Exam Ordered:** \_\_\_\_\_  
**Procedure (CPT) Code:** \_\_\_\_\_  
**Diagnosis Code(s):** \_\_\_\_\_

*Please circle appropriate contrast option*

With Contrast	Without Contrast
With & Without Contrast	Not Applicable

**Please attach clinical documentation ( Physician Notes, Labs, Prior Exams)**

**REFERRING PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Tax ID: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

**AUTHORIZATION INFORMATION**

Approval Number: \_\_\_\_\_ Date Received: \_\_\_\_\_  
Expires On: \_\_\_\_\_  
Reason for Denial: \_\_\_\_\_

**COLUMBIA FAX: 410-740-9399**

**BALTIMORE FAX: 410-605-9397**