RADIOLOGY ASSOCIATES OF OCALA, P.A.

REQUEST TO OBTAIN AUTHORIZATION

TO BE COMPLETED BY THE REFERRING OFFICE:

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

EXAM(S): _____

_____

INSURANCE CARRIER: _____

MEMBER ID: _____ **GROUP NUMBER:** _____

SUBSCRIBER'S NAME: _____

ORDERING PHYSICIAN/CLINICIAN: _____

ORDERING PHYSICIAN/CLINICIAN TAX ID: _____

ORDERING PHYSICIAN/CLINICIAN NPI#: _____

ORDER PHYSICIAN/CLINICIAN ME#: _____

****IMPORTANT*** PLEASE FAX OR EMAIL A COPY OF THE MOST RECENT OFFICE/PROGRESS NOTE ALONG WITH THIS FORM (FAX # 352-732-8010)**

TO BE COMPLETED BY INSURANCE AUTHORIZATION DEPARTMENT:

AUTHORIZATION OBTAINED BY: _____

AUTHORIZATION NUMBER: _____

AUTHORIZATION EXPIRATION: _____

ADDITIONAL NOTES: _____

_____

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