

PRIOR AUTHORIZATION REQUEST

MRI Lumbar Spine

PATIENT INFORMATION

Patient Name:

Date of Birth:

Member ID:

CLINICAL INFORMATION

Primary Diagnosis:

Secondary Diagnosis:

Procedure Code:

Requested Date of Service:

Clinical Justification:

PROVIDER INFORMATION

Provider Name:

Provider NPI:

Facility Name:

This form is for demonstration purposes only.

AuthScript Prior Authorization Demo