PARAMOUNT
ELITE | COMMERCIAL/HMO

OUTPATIENT IMAGING PRIOR AUTHORIZATION REQUEST FORM

Attn: Paramount U/CM Department

Toll Free Phone Number: 1-800-891-2520 Fax: 567-661-0844

Network Provider Pre-service Request - PAMA SCORE: _____(scores ≥ 8 receive administrative approval)

DATE OF REQUEST:_____ DATE OF PROCEDURE: _____

MEMBER NAME: _____ DOB: _____

PARAMOUNT MEMBER ID: _____Paramount Secondary ID#:_____
(if applicable)

ORDERING PHYS:_____ ORDERING PHYS NPI#:_____

CONTACT NAME: _____ PHONE:_____ FAX: _____

FACILITY PERFORMING PROCEDURE: _____

FACILITY TAX ID#: _____ NPI#: _____

FACILITY ADDRESS: _____

FACILITY PHONE: _____ BILLING OFFICE PHONE: _____

Solid Organ Transplant Request: ☐ Yes ☐ No

PLEASE COMPLETE STEPS 1 - 4

1. BODY PART TO BE TESTED:_____
2. PLEASE CHECK TEST TO BE PERFORMED:
   - ☐ MRI SCAN – CPT: _____
   - ☐ MRA SCAN – CPT:_____
   - ☐ CT SCAN – CPT: _____
   - ☐ CTA – CPT: _____
   - ☐ PET SCAN – CPT: _____
   - ☐ CARDIAC STRESS TEST CPT: _____
3. DIAGNOSIS: _____
4. ICD-10:_____
5. MEDICAL/CLINICAL HISTORY (Clinical Notes Required For Review):

Current signs and symptoms:_____

_____

Results of any other pertinent diagnostic testing: _____

_____

Consult or other treatment documentation supporting rationale for procedure: _____

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