of Tennessee

High Tech Imaging Prior Authorization Request Form

To request services for Commercial fax to 1-866-558-0789.

Requests can be submitted online at any time through **Availity.com**.

Submitter Contact Information

Name: _____

Phone: _____ Fax: _____

Member Information

Member Name:_____

Member ID Number: _____ Member Gender:_____

Member Address: _____

Member Phone Number: _____ Date of Birth: _____/_____ / _____

Primary Diagnosis for requested service, (list ICD-10 Codes):

Ordering Physician

Ordering Physician:_____

Provider Number: _____

Phone Number: _____ Fax Number:_____

National Provider Identifier: _____ Tax ID: _____

Address: _____

Treating Facility Information

Treating/Facility Name: _____

Provider Number: _____

Phone Number: _____ Fax Number:_____

National Provider Identifier: _____ Tax ID:_____

Address: _____

Please include applicable procedure(s) names and code(s) below.

Please include specific clinical supporting the medical necessity of the requested items.

Name/Description	CPT®/HCPCS

Clinical Information

Past medical history, provider's orders/treatment plan, IV meds, oxygen support, all pertinents lab values, all pertinent diagnostic testing, wound description and care, nutrition/diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information. Please attach imaging reports if applicable.

Disclaimer: Certification is not a confirmation of coverage or benefits; payment will be subject to policy provisions.

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