Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

Pre-Authorization Department

Phone: 646-962-7099 **Fax:** 646-962-0122

PATIENT INFORMATION

Patient Name: ____ **MRN#:** _______________________

Date of Service: _________________

Exam(s): _____________________________________ **CPT Code:** _________ **ICD 10 Code:** _________

_____________________________________ **CPT Code:** _________ **ICD 10 Code:** _________

_____________________________________ **CPT Code:** _________ **ICD 10 Code:** _________

Insurance Name: _____________________________________ **ID#:** ___________________________

REQUESTING/REFERRING PHYSICIAN INFORMATION

Ordering Physician Name: ____ **Specialty:** ______________________

Tax ID#: _________________ **NPI#:** ___________________

Address: ____

Phone#: ________________________________ **Fax#:** ________________________________

PLEASE PROVIDE THE FOLLOWING INFORMATION (UNLESS NOTED IN EPIC):

- **Primary Working Diagnosis Code(s)**
- **Signs/Symptoms**
- **Reason or Rule Out**
- **First and Last office visit date for this condition**
- **Findings on Physical Exam**
- **Relevant Previous Medical History**
- **Treatment pertaining to condition – including physical therapy, antibiotics, pain medication etc.**
- **Prior imaging and Relevant Labs – diagnostic imaging, date of service and impression**

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PLEASE BE ADVISED WE MAY CONTACT YOUR OFFICE IF A PEER-TO-PEER IS REQUIRED

Person Completing Form: __________________________ **Direct Contact/Extension:** _______________

Signature: _____________________________________ **Date:** _____________