



PINAL COUNTY
Wide open opportunity

**PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL
RADIOLOGY SERVICES
PLEASE FAX ALL REQUESTS TO (520) 866-6717**

MEMBER NAME: _____ MEMBER ID: _____

DOB: _____ OTHER INSURANCE: _____ MEDICARE A B

EPSDT eligible member? Yes NO CRS Eligible member? Yes No

REQUESTED PROVIDER: _____ ID: _____ PHONE: _____ FAX: _____

URGENCY STATUS (see * for definitions of status):

- Standard (Based on members' condition – Not to exceed 14 days)
- Expedited – Urgent (within 3 days)

Date of Service: _____ Appointment Time: _____

Service Requested:

Diagnosis Code	Requested CPT Code	Estimated Cost	Diagnosis Code	Requested CPT Code	Estimated Cost	Other Codes Requested	Estimated Cost

For MRIs the following questions must be completed:

1. Will a CT scan obtain the desired information? Yes NO
If so, a CT will be approved. If after the results of the CT and MRI is still required fax results of CT with referral for MRI and it will be re-reviewed. Keynote: A prior CT scan is not required for C-Spine MRI requests.
2. What are the presenting clinical symptoms related to MRI request? _____

3. What is the Dr. expecting to find on the MRI? _____

4. What type of treatment modality are you expecting to implement upon obtaining the results of the MRI? _____

5. If applicable, has member seen a neurologist? Yes No
If so, please attach documentation.

For requests over \$500, please attach documentation to support medical necessity (Mandatory)

1. PCP order (if referral form is not signed by PCP)
2. Most recent History and Physical
3. Physical progress notes, which evaluate condition requiring radiology or laboratory service.

Referring Provider Information:

Provider Name: _____ ID Number: _____ Contact: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Date: _____

PCP/PCP Designee Signature: _____

PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records.

**Standard Authorization Request:* This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

Expedited Authorization Request: A request that P/GLTC provide a decision to the member as promptly as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to come to a decision.

Referral authorization is not guarantee of payment.