Medical Prior Authorization Form

Patient Information	
Name:	Date of Birth:
Emma Johnson	March 12, 1999
Insurance ID:	Group Number:
A124-BX	A124-BXA
Policyholder's Name (if different): Phil Johnson	
Provider Information	
Healthcare Provider's Name:	National Provider Identifier:
Anna Lee, MD	145-DQM-00
Address: 4501 Rockford Mountain Lane Selma NC	
Phone Number:	Fax Number:
919-965-0813	919-631-4495
Authorization Request Details	
Date of Request:	Procedure / Service Requested:
August 1, 2023	MRI of Lumbar Spine
CPT Code:	Diagnosis Code:
72148	M54.16
Requested Start Date:	Anticipated Duration of Treatment:
August 12, 2023	N/A
Clinical Justification	
The patient is experiencing persistent lower back pain, and an MRI of the lumbar spine is necessary for accurate diagnosis and treatment planning.	
Prescribing Physician's Information (if applicable)	
Physician's Name:	National Provider Identifier:
Gale Chua, MD	780-AD1-00
DEA Number (if applicable):	Phone Number:
	919-631-4488

Patient Consent	
I, the undersigned, understand that the requested procedure or service is subject to prior authorization by my insurance provider. I authorize the release of any necessary medical information for the purpose of obtaining this authorization.	
	August 1, 2023
Patient's Signature	**Date**
Provider's Certification	
I certify that the information provided is accurate and complete to the best of my knowledge. I understand that providing false information may result in denial of the authorization request.	
	August 1, 2023
Provider's Signature	**Date**
Please attach any supporting documentation such as medical records, test results, or physician notes for clinical justification.	