AUTHORIZATION FORM

Auth/Precert Department (631) 444-5544 Ext 2700

ZWANGER-PESIRI RADIOLOGY
zprad.com

PLEASE FAX ALL 4 OF THE FOLLOWING TO 631-992-6463:

1. REFERRAL SLIP 2. CLINICAL INFORMATION / MEDICAL RECORDS 3. PATIENT INSURANCE CARD 4. THIS FORM

PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

STREET ADDRESS | APT./SUITE #

CITY | STATE | ZIP

( ) - CELL PHONE # | ( ) - HOME PHONE # | ( ) - WORK PHONE # | / / DATE OF BIRTH

EXAM INFORMATION

EXAM REQUESTED | CPT CODE

SIGNS & SYMPTOMS (NOT RULE/OUT)

IDC 10 CODE

SPECIFIC RULE/OUT

FINDINGS ON PHYSICAL EXAM

APPROXIMATE DATE OF ONSET CONDITION | APPROXIMATE DATE OF FIRST OFFICE VISIT TO ANY PHYSICIAN FOR THIS PROBLEM

DATE OF MOST RECENT OFFICE VISIT | TODAY'S DATE

KEY CONTACT PERSON

LAST NAME | FIRST NAME

EMAIL ADDRESS

REQUESTING/REFERRING PHYSICIAN

X

SIGNATURE (REQUIRED) | DATE / /