Authorization Request Form - High Tech Imaging

Please complete this form and attach supporting clinical documentation. For fax numbers and frequently asked questions, visit **https://payerinfo.zendesk.com/hc/en-us/categories/10629830321047-Fax-Forms-and-Resources**

Don't want to fax anymore? You could be getting time-saving benefits, including automatic approvals and guided submissions by using the portal. Registration only takes a few minutes, and unlocks access for all users at your practice organization. **Visit www.coherehealth.com/register to begin.**

Patient information

Patient first name **required*	Patient last name **required*
Member ID **required*	Date of birth (MM/DD/YYYY) **required*

Requestor information

Requestor first name **required*	Requestor last name **required*
Requestor email **required*	Requestor phone number **required*
Requestor fax number **required*	Requestor type (please ☒ one of the following options) **required* ☐ Ordering provider ☐ Performing provider ☐ Facility

Diagnosis codes

Primary diagnosis code **required*	Secondary diagnosis code	Secondary diagnosis code

Service details

Start date (MM/DD/YYYY) **required*	End date (MM/DD/YYYY)

Procedure codes

CPT/HCPCS code 1 **required*	Units **required*	CPT/HCPCS code 6	Units **required*
CPT/HCPCS code 2	Units	CPT/HCPCS code 7	Units
CPT/HCPCS code 3	Units	CPT/HCPCS code 8	Units
CPT/HCPCS code 4	Units	CPT/HCPCS code 9	Units
CPT/HCPCS code 5	Units	CPT/HCPCS code 10	Units

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Ordering provider

Name **required*		Street address
City	State	Zip code
National Provider Identifier (NPI) **required*		Taxpayer Identification Number (TIN) **required*
Fax number		Phone number

Treating facility

Name **required*		Street address
City	State	Zip code
National Provider Identifier (NPI) **required*		Taxpayer Identification Number (TIN) **required*
Fax number		Phone number

Expedite request

☐ Expedite this request

In order for a case to be expedited the physician (or other clinician) must indicate that applying the standard timeframe could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. If the date of service is greater than 3 days in the future, please DO NOT submit this request as expedited.

Please provide physician (or other clinician) justification

Physician (or other clinician) signature

Please attach any relevant clinical documentation to this form and fax it to Cohere.

Have a question about this form?
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Fax forms are updated periodically to reflect the most recent authorization requirements
visit our website for the latest version.