Reno Diagnostic Centers
When it has to be done right.

Scheduling & Pre Authorization Fax Request

20161018-001

Fax to: 775-333-2776

Date: ______________________

PATIENT INFORMATION

Patient's Name: ____________ (Last) ____________ (First) ____________ (Middle)

Date of Birth (MM/DD/YYYY): ____________ SSN: ____________

Gender: ☐ Male ☐ Female Pregnant? ☐ Yes ☐ No Height: ________ Weight: ________

Telephone: Home: ________ Work: ________ Mobile: ________

Email: ____________ Employer: ____________

Previous Films? ☐ Yes ☐ No Location: ____________ Phone No.: ____________

SERVICES REQUESTED

Procedure #1 to be Scheduled: ____________ ☐ Left ☐ Right ☐ Bilateral

Contrast: ☐ W/ ☐ W/O ☐ W/ & W/O

Procedure #1 Diagnosis: ____________ ICD-10 Code: ____________

Procedure #2 to be Scheduled: ____________ ☐ Left ☐ Right ☐ Bilateral

Contrast: ☐ W/ ☐ W/O ☐ W/ & W/O

Procedure #2 Diagnosis: ____________ ICD-10 Code: ____________

Additional Exam(s) / Notes: ____________

INSURANCE INFORMATION

Primary Ins. Company: ____________ Secondary Ins. Company: ____________

Subscriber (if different than patient): ____________

☐ Referring Office to Obtain Authorization ☐ No Authorization Required ☐ Reno Diagnostic Centers to Obtain Authorization

Authorization No.: ____________ Authorization No.: ____________

IMPORTANT! If you want Reno Diagnostic Centers to obtain pre-authorization from your patient's insurance carrier, you **MUST** submit the following information/documentation with this form:

- ☐ Front and Back of Patient's Insurance Card
- ☐ Complete Patient Demographics (Home Address, Employer's Address and Phone No., Emergency Contact Information, etc.)
- ☐ H&P (Clinicals). Please include complete dictation, prior imaging, and pathology reports (if applicable).

REFERRING OFFICE INFORMATION

Office Admin Contact: ____________ (Last) ____________ (First)

Phone: ____________ Fax: ____________

Ordering Physician: ____________ (Last) ____________ (First)

Send Additional Report Copy to (enter Physician's Name): ____________ (Optional)

Physician's Signature (Required): ____________