



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON  
MEDICAL ADMINISTRATORS,  
INCORPORATED

**REQUEST FOR PRIOR AUTHORIZATION FOR DIAGNOSTIC IMAGING**

\*\*\*PLEASE PRINT OR TYPE ALL INFORMATION\*\*\*

RECIPIENT NAME: \_\_\_\_\_ RECIPIENT DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 DOES RECIPIENT HAVE ALTERNATE INSURANCE PLAN?  YES  NO PART B  YES  NO In/Out?  YES  NO  
 NAME OF INSURANCE PLAN: \_\_\_\_\_ RECIPIENT MEDICAID ID: \_\_\_\_\_  
 CPT CODE: \_\_\_\_\_ DIAGNOSIS CODE: \_\_\_\_\_ DATE REQUESTED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 PROVIDER NAME: \_\_\_\_\_ NH MEDICAID PROVIDER #: \_\_\_\_\_  
 TELEPHONE #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ CONTACT PERSON NAME: \_\_\_\_\_  
 FACILITY/HOSPITAL: \_\_\_\_\_ CONTACT PERSON #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

PROCEDURE(S) BEING REQUESTED:  With Contrast  Without Contrast  With & Without Contrast

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> CT Head (Brain)   | <input type="checkbox"/> CT Angiography – Upper Extremity  | <input type="checkbox"/> MRI Cardiac (Heart)                                     |  |
| <input type="checkbox"/> CT Maxillofacial Area                                   | <input type="checkbox"/> CT Angiography – Lower Extremity  | <input type="checkbox"/> MRI Breast Unilateral                                   |  |
| <input type="checkbox"/> CT Orbit, Sella, Ear                                    | <input type="checkbox"/> CT Angiography – Abdominal Aorta & bilateral iliofemoral lower extremity runoff | <input type="checkbox"/> MRI Breast Bilateral                                    |  |
| <input type="checkbox"/> CT Soft-Tissue Neck                                     | <input type="checkbox"/> PET Scan – Limited Area   | <input type="checkbox"/> MRI Bone Marrow Blood Supply                            |  |
| <input type="checkbox"/> CT Chest  | <input type="checkbox"/> PET Scan – Skull Base to Mid-Thigh  | <input type="checkbox"/> MR Guidance Procedure (Specify CPT Code/Describe) _____ |  |
| <input type="checkbox"/> CT Chest (Follow Up)                                    | <input type="checkbox"/> PET Scan – Whole Body   | <input type="checkbox"/> MR Angiography – Head                                   |  |
| <input type="checkbox"/> CT Cervical Spine (C-spine)                             | <input type="checkbox"/> PET/CT Fusion Scan – Limited Area   | <input type="checkbox"/> MR Angiography – Neck                                   |  |
| <input type="checkbox"/> CT C-Spine Post Myelogram                               | <input type="checkbox"/> PET/CT Fusion Scan – Skull Base to Mid-Thigh                                    | <input type="checkbox"/> MR Angiography – Chest Non Cardiac                      |  |
| <input type="checkbox"/> CT Thoracic Spine (T-Spine)                             | <input type="checkbox"/> PET/CT Fusion Scan – Whole Body   | <input type="checkbox"/> MR Angiography – Abdomen                                |  |
| <input type="checkbox"/> CT T-Spine Post Myelogram                               | <input type="checkbox"/> PET Scan – Brain  | <input type="checkbox"/> MR Angiography – Pelvis                                 |  |
| <input type="checkbox"/> CT Lumbar Spine (L-Spine)                               | <input type="checkbox"/> MRI Head (Brain)  | <input type="checkbox"/> MR Angiography – Spinal Cana                            |  |
| <input type="checkbox"/> CT L-Spine Post Myelogram                               | <input type="checkbox"/> MRI Temporomandibular (TMJ) Joint   | <input type="checkbox"/> MR Angiography – Upper Extremity                        |  |
| <input type="checkbox"/> CT Abdomen  | <input type="checkbox"/> MRI Orbit, Face Neck  | <input type="checkbox"/> MR Angiography – Lower Extremity                        |  |
| <input type="checkbox"/> CT Abdomen (Follow Up)                                  | <input type="checkbox"/> MRI Chest   | <b>NUCLEAR CARDIAC IMAGING</b>   |  |
| <input type="checkbox"/> CT Renal Stone Survey                                   | <input type="checkbox"/> MRI Cervical Spine (C-Spine)  | <u>Myocardial Perfusion Imaging (MPI)</u>  |  |
| <input type="checkbox"/> CT Pelvis   | <input type="checkbox"/> MRI Thoracic Spine (T-Spine)  | <input type="checkbox"/> MPI Tomographic SPECT Single Study                      |  |
| <input type="checkbox"/> CT Upper Extremity                                      | <input type="checkbox"/> MRI Lumbar Spine (L-Spine)  | <input type="checkbox"/> MPI Tomographic SPECT Rest & Stress                     |  |
| <input type="checkbox"/> CT Lower Extremity                                      | <input type="checkbox"/> MRI Abdomen   | <input type="checkbox"/> MPI Wall Motion   |  |
| <input type="checkbox"/> CT Guidance Procedure (Specify CPT Code/Describe) _____ | <input type="checkbox"/> MRI Pelvis  | <input type="checkbox"/> MPI Ejection Fraction                                   |  |
| <input type="checkbox"/> CT Angiography – Head                                   | <input type="checkbox"/> MRI Upper Extremity Other Than Joint  | <input type="checkbox"/> Cardiac Blood Pool Imaging (MUGA) (Single)              |  |
| <input type="checkbox"/> CT Angiography – Neck                                   | <input type="checkbox"/> MRI Upper Extremity Any Joint   | <input type="checkbox"/> PET Scan – Cardiac                                      |  |
| <input type="checkbox"/> CT Angiography – Chest                                  | <input type="checkbox"/> MRI Lower Extremity Other Than Joint  |  |  |
| <input type="checkbox"/> CT Angiography – Abdomen                                | <input type="checkbox"/> MRI Lower Extremity Any Joint   |  |  |
| <input type="checkbox"/> CT Angiography – Pelvis                                 |  |  |  |

**CLINICAL INFORMATION:**

Please attach clinical notes supporting the medical necessity for the requested services, including but not limited to the following: Medical Care Plan, Relevant Diagnostic Tests, and Progress Notes.

**CERTIFICATION OF MEDICAL NECESSITY  
(to be signed by ordering physician requesting the service)**

I certify that the requested treatments and /or procedures are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

\_\_\_\_\_  
Signature Date

Please print:  
\_\_\_\_\_  
Name/Title Specialty