


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 <i>*required</i>	Patient last name <i>*required</i>
Member ID <i>*required</i>	Date of birth (MM/DD/YYYY) <i>*required</i> _ _ / _ _ / _ _ _ _

Requestor information

Requestor first name <i>*required</i>	Requestor last name <i>*required</i>
Requestor email <i>*required</i>	Requestor phone number <i>*required</i> _ _ _ - _ _ - _ _ _ _
Requestor fax number <i>*required</i> _ _ _ - _ _ - _ _ _ _	Requestor type (please <input checked="" type="checkbox"/> one of the following options) <i>*required</i> <input type="checkbox"/> Ordering provider <input type="checkbox"/> Performing provider <input type="checkbox"/> Facility

Diagnosis codes

Primary diagnosis code <i>*required</i> _ _ _ . _ _ _ _	Secondary diagnosis code _ _ _ . _ _ _ _	Secondary diagnosis code _ _ _ . _ _ _ _
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Service details

Start date (MM/DD/YYYY) <i>*required</i> _ _ / _ _ / _ _ _ _	End date (MM/DD/YYYY) _ _ / _ _ / _ _ _ _
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Procedure codes


CPT/HCPCS code 1 <i>*required</i> _ _ _ _	Units <i>*required</i> _ _	CPT/HCPCS code 6 _ _ _ _	Units <i>*required</i> _ _
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 <i>*required</i>		Street address	
City	State	Zip code	
National Provider Identifier (NPI) <i>*required</i>		Taxpayer Identification Number (TIN) <i>*required</i>	
Fax number		Phone number	

Treating facility

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

Expedite request

<input type="checkbox"/> 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?

Visit <https://payerinfo.zendesk.com/hc/en-us/categories/10629830321047-Fax-Forms-and-Resources>

Fax forms are updated periodically to reflect the most recent authorization requirements visit our website for the latest version.

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