



Care Management
Outpatient MRI, MRA, CT and PET Imaging

Prior Authorization Request

Fax the completed form to (816) 271-1266.

Questions? Call (816) 271-4019 press 2

Or (800) 990-9247 press 3, then 2

**If the test is to be done in less than 24 hours
call (816)271-4019 prior to faxing.**

Member Name: _____ Date of Birth: _____

Requesting Physician: _____

Contact Person: _____ Phone Number: (____) _____ - _____ Fax Number:
(____) _____ - _____

Check the type of imaging and write the body area to be imaged.

MRI _____ CT _____

MRA _____ PET _____

Date scheduled: _____ Place of Imaging Service: _____

Reason for Imaging:

Results of previous imaging done for this same chief complaint or diagnosis in the last 6 months:

CHP office use only:

Date requested information received: _____

Date determination made: _____

Approved? Yes, No, denied per Medical Director. Denial
reason _____

Does Medical Director want to review the scan results?

If yes, please highlight this area.

The information contained in this facsimile message is privileged and confidential and intended for the use of the addressee listed below. If you are not the intended recipient of the facsimile and you have received this information in error, please destroy the information and if possible, notify the sender at the phone number above.