

# DIAGNOSTIC IMAGING PRE-AUTHORIZATION AND ORDER FORM

SCHEDULING: (480) 425-5030  
AUTHORIZATION FAX: (480) 425-5035  
MAIN PHONE: (480) 425-5000  
www.esmil.com

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone Number(s): \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Primary Insured's Name: \_\_\_\_\_

Procedure(s): \_\_\_\_\_

Working Diagnosis(es)/ICD9(s): \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Office Contact Phone Number: \_\_\_\_\_

PCP: \_\_\_\_\_

Ordering Physician (print): \_\_\_\_\_

Ordering Physician's Tax ID: \_\_\_\_\_

Ordering Physician (signature): \_\_\_\_\_ Date: \_\_\_\_\_

This form must be accompanied by copy of patient ID card(s), medical notes and/or previous imaging reports that support medical necessity for procedure(s) ordered.