Date: [Insert Date]

To: [Imaging Center Name]
Address: [Imaging Center Address]
Fax/Email: [Imaging Center Contact Info]

RE: RADIOLOGY AUTHORIZATION REQUEST

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury: [DOI]
Claim Number: [Claim #]
Employer: [Employer Name]

Workers Comp Carrier: [Insurance Company Name]
Adjuster Name: [Adjuster Name]
Adjuster Phone: [Phone Number]
Adjuster Email: [Email Address]

Requested Procedure(s):

- [Type of Scan, e.g., MRI, X-Ray, CT]
- [Body Part and Side, e.g., Right Knee]
- [With or Without Contrast]
- **ICD-10 Diagnosis Code:** [Code]

Clinical Indication/Reason for Exam:
[Brief description of symptoms or medical necessity]

Referring Physician Information:
Physician Name: [Doctor Name]
NPI Number: [NPI #]
Clinic Name: [Clinic Name]
Phone: [Phone Number]
Fax: [Fax Number]

Authorization Status:
[ ] Verbal Authorization obtained from Adjuster
[ ] Written Authorization attached
[ ] Pending Authorization - Please contact adjuster for approval

Please send the radiology reports and images via [Fax/Portal/Mail] to the referring physician listed above upon completion of the study.

Sincerely,

[Your Name/Signature]
[Your Title]