Phone: 718-907-2380
Fax: 718-907-2389

MAIN STREET RADIOLOGY

Authorization Form

Date_____

Exam Requested_____ CPT CODE:_____

ICD 10 (Primary):_____ ICD 10 (Secondary):_____

Date Of First Visit/Onset Of Problem: _____

Please Fax **ALL** of the following to 718-907-2389
Referral Slip, Clinical Information/Medical Records, Patient Insurance Card, and This Form

REQUESTING REFERRING PHYSICIAN INFORMATION

Last Name: _____ First Name:_____

Address:_____

City/State/Zip:_____ Specialty:_____

Telephone#_____ NPI/Lic:_____

Fax#_____ TIN#_____

Name of person completing this form:_____

PATIENT INFORMATION

Last Name:_____ First Name:_____

Address:_____

City/State/Zip:_____

Primary Telephone#_____ Secondary Telephone#_____

DOB:_____ Social Security:_____

INSURANCE INFORMATION

Insurance Co. Name:_____

Address:_____

City/State/Zip:_____

Policy #:_____ Group #_____

Relationship to Patient Employer Name:

Requesting/Referring Physician (Signature Required): _____