



# North State Radiology

Chico Breast Care Center  
North State Imaging

North Valley Advanced Imaging  
North State Interventional Radiology

## PRE-AUTHORIZATION INFORMATION REQUEST

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

EXAM REQUESTED: \_\_\_\_\_

REFERRING PROVIDER NAME: \_\_\_\_\_

FAXED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

Thank you for the referral to our center. To assist us in obtaining prior authorization, please **FAX** the order and relevant clinical history for the exam being ordered to include the following documentation to **(530) 894-0174**:

- The specific diagnosis and/or ICD-10 code for the exam ordered: \_\_\_\_\_
- Date of injury or onset of symptoms: \_\_\_\_\_
- Has the patient had a prior x-ray or imaging exam?     Yes     No
- Has the patient had 6 or more weeks of Physical Therapy?     Yes     No
- Has the patient been prescribed pain medication?     Yes     No
- Has the patient had prior surgery for the condition?     Yes     No
- Has the patient had spinal injections for the condition?     Yes     No
- Does the treatment plan include surgery or spinal injections ?  
     No     Yes     Procedure: \_\_\_\_\_
- Does the patient have a history of cancer?     Yes     No  
    If Yes, what type: \_\_\_\_\_

Additional Info: \_\_\_\_\_

\_\_\_\_\_

Thank you for your assistance.

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North Valley Advanced Imaging

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