Radiology Notification Form

Please complete each section of this form. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

Procedure Information

ICD code(s), please list all that apply: _____

CPT(s), please list all that apply: _____

Place of Service: _____

Date of Image: _____

Ordering Provider Information

Provider Name: _____

Clinic Name: _____

Phone Number: _____ Fax Number: _____

Imaging Facility/Site Information

Imaging Facility: _____

Phone Number: _____ Fax Number: _____

Person completing the form: _____ Today's Date: _____

Your Phone Number: (_____) _____ Your Fax Number: (_____) _____

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact DAKOTACARE Service Center at 605-334-4000 or toll-free at 1-800-658-5508. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to DAKOTACARE at **1-605-274-3279** or send a secure email to HealthServices@DAKOTACARE.com.