ECHN
Eastern Connecticut Health Network, Inc.

MANCHESTER MEMORIAL HOSPITAL
71 Haynes Street, Manchester, CT 06040

ROCKVILLE GENERAL HOSPITAL
31 Union Street, Vernon, CT 06066

ECHN & Tolland Imaging Center (TIC, LLC)
Authorization Program
Doctor Information and Consent

Practice Name:_____ TAX ID:_____

Specialty:_____

Practice Address:_____

Phone:_____ Fax:_____

Back Line or Direct Hospital Extension:_____

Physician Name:_____ NPI:_____

Aetna Provider ID#_____
Blue Cross ID#_____
CT Care ID#_____
CT Medicaid ID#_____
CT Medicare ID#_____
Oxford Provider ID#_____
Harvard Pilgrim Provider ID#_____
United Health Care ID#_____
Wellcare Medicare ID#_____

To Insurance Provider,

I am authorizing Prospect ECHN, Inc. and Tolland Imaging and it's employees to obtain authorizations on behalf of the above named physician for outpatient services, effective as of_____ .

Prior authorization requests will provide the Insurance Provider with the patient name, date of service, site address, order specifics (including scan type, reason, location on the body, CPT code) and any required medical history, clinical information, to obtain Prior Authorization.

In addition, should a peer−to−peer review be required in order to obtain the Prior Authorization, please communicate that to the staff of Prospect ECHN, Inc. and/or Tolland Imaging and they will advise my office so that a review may be scheduled.

I authorize Prospect ECHN, Inc. and Tolland Imaging to create accounts with online databases for Authorization and/or Verification purposes. If account are already active, I allow utilization of them by providing User Name and Password information.

This authorization is valid for one year from the date indicated below. A photocopy or facsimile of this authorization shall be deemed an original for the purporses of this document only.

_____ _____
Authorized Provider Signature Date/Time

_____ _____
Printed Name Title