



Required Pre-Authorization Form
For EXERCISE NUCLEAR STRESS TEST
Procedure Codes: 78452
be completed by Referring Physician/Practice

Thank you for referring your patient to us for a EXERCISE NUCLEAR STRESS TEST. In order to schedule your patient for the test, **this form must be completed and returned** to The Heart Care Group, P.C. by **2 p.m. the day prior** to the patient's appointment.

If we do not receive this form by 2 p.m. the day prior to the appointment, you will be contacted by us to reschedule your patient. *Please do not give the Authorization Number to the patient.*

Patient's Name: _____ DOB: _____

Patient's Insurance: _____

Pre-Authorization Phone Number: _____

Your patient is scheduled on _____ at the following location:

1202 South Cedar Crest, Suite 500, Allentown

858 Interchange Road, Lehighton

This section to be completed by Referring Physician/Practice

Pre-Authorization Number: _____ Expires: _____

No Pre-Authorization Number Needed

FAX this form to: 610-432-4766

If you have any questions regarding this Required Pre-Authorization form , please contact SHERRY at 610-778-2373.

If preauth cannot be obtained, please contact scheduling to cancel or to reschedule if a different test is to be done. 610-770-2200 – opt #2.

Thank you. Your cooperation is greatly appreciated.

NOTE: This is not a request for a referral.