Mass General Brigham
Wentworth-Douglass Hospital

WDH Financial Clearance Authorization Form

Please fill out the form below completely as any non-completed form will be returned.
Imaging/Diagnostics fax: 603-740-2398

Patient Name:	DOB:
Address:	
Insurance Company:	ID #
Ordering/requesting Provider Name and NPI:	
Test/ Procedure name:	
Comments/Additional information:	
All ICD 10 codes with description of primary DX:	
All CPT/HCPC codes:	
Contrast level if applicable:	
Date of Service- expected or scheduled:	
Authorization #:	Validity dates:
Authorization info (please include the following, date and time of call, phone #, name of rep, call ref # or website used):	
Place of Service (Location, address, NPI and Tax ID):	
Office contact name:	Phone:
Email:	Fax:
Please attach clinical documents/imaging related to services being requested, copy of Authorization and copy of insurance card if available.	

Ordering Provider Signature: (this is only required if you are using this as the order form):	Date: