SAINT AGNES
SETON IMAGING

PERMISSION FOR SETON IMAGING TO OBTAIN INSURANCE CARRIER AUTHORIZATIONS

I, _____ give Saint Agnes/Seton Imaging permission to obtain authorizations for any/all patients that I refer to the facility for diagnostic testing. I understand Saint Agnes Healthcare/ Seton Imaging will be acting on my behalf and I agree to provide medical records as needed to complete such requests.

Physician Group Name

Physician Specialty

Physician Name/Address

Tax ID Number

NPI Number

Office Contact

Name: _____
Phone: _____
Fax: _____

Physician Signature _____

Date _____

Please note: A separate form will be required for each referring physician within the group practice

FAX COMPLETED FORM TO: (410) 368-3527

Please visit us online @ www.Setonimagingcenter.com