### Diagnostic Imaging Pre-Authorization Form

This form is designed to obtain prior authorization for Magnetic Resonance Imaging (MRI) and Computerized Tomography Scan (CT Scan) as approved by NHIF. All fields relevant to the needed service(s) **MUST** be completed to inform pre-authorization decision. Turnaround for response is **up to 24 working hours once all relevant** information has been received.

- Payments contingent upon validity at the time of service and providers shall be responsible for ascertaining beneficiary eligibility to utilize the approved diagnostic procedure(s).
- Services not pre-authorized shall not be reimbursed.
- Results of preliminary radiological examination(s), where necessary, shall accompany this request (e.g. X-ray/Ultrasound/ECG/EEG and others, whichever is applicable).
- Need for MRI/CT scan shall be ascertained and prescribed by **Medical Specialist (Consultant)**.
- Radiological test results must be transmitted to the referring health care provider.

### SECTION 1: Patient Information

*To be filled by the patient*

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Other Names:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relationship:** Principal Member: [ ] Spouse: [ ] Child: [ ] NHIF Member No: [ ]

**Patients ID No:** [ ] **Member ID No:** [ ] **Patients Phone No:** [ ]

I certify that the above information is correct and give specific consent for selected diagnostic imaging service(s) to be done. I undertake to pay any monies not catered for by my medical scheme, subject to scheme rules and necessity of the services. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act.

**Signature:** ________________________  **Date:** ______________

### SECTION 2: Request for Imaging Service

*To be filled by the requesting doctor*

<table>
<thead>
<tr>
<th>[ ] Computed Tomography Scan (CT-SCAN)</th>
<th>[ ] Magnetic Resonance Imaging: (MRI)</th>
</tr>
</thead>
</table>

- [ ] Head and Neck  [ ] Spine  [ ] Body/Trunk  [ ] Extremity  [ ] Joint
- [ ] Other aspects of the body (specify) ........................................................................................................

**Primary Diagnosis:**

**ICD 10 code:**

**Servicing Location:** [ ] Inpatient  [ ] Outpatient  **Date of Service:**
### SECTION 3: REQUESTING SPECIALIST/CONSULTANT INFORMATION

To be filled by specialist/consultant at the capitated health facility. In cases where patient has been referred to a specialist/consultant you are required to attach a certified referral letter. Note that for scheme beneficiaries accessing benefits under Fee for Service Payment mechanism a referral letter to the specialist center/unit must be attached.

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Facility Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Contact Person:</td>
<td>Patient OPC/IPC NO.</td>
</tr>
<tr>
<td>E-mail:</td>
<td>Phone No:</td>
</tr>
</tbody>
</table>

**Requesting Doctor’s Names:**

| Practice Specialty: | KMPDB Registration No: |

**CLINICAL INFORMATION:** Justification for the radiology procedure request (brief treatment history, treatment plan, medication and previous imaging results).

Requesting Doctor’s Signature: ___________________________  Date: ___________________________

### SECTION 4: SERVICE RENDERING PRACTITIONER/FACILITY

To be completed by a radiologist at the imaging center where the patient has been referred to:

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Hospital Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiologist’s Names:</td>
<td>Registration No.</td>
</tr>
</tbody>
</table>

**Brief outcome of procedure / Imaging Report comments:** attach the MRI/CT-Scan report

I certify that I have shared the radiological results with the client and instructed them to return the report to referring health care provider.

**Servicing Radiologist/Radiographer’s Signature:** ___________________________  Date: ___________________________

### NOTE

- Please be advised that authorization is based upon the medical information provided. If services, providers or dates of services change from these indicated, NHIF must be notified prior to services being rendered.
- Payment for services rendered is subject to verification of outcomes of care and beneficiary eligibility as at the date of service provision. Contractual obligations with the provider take precedence.
- Beneficiaries below 18 years must have their Section 3 filled and signed by the Principal Contributor.
- Complete and attach this document to the Claim form (NHIF 8) clearly indicating the Pre authorization number and the L.O.U. Number.

This Pre-authorization entails the package as prescribed in the approved NHIF benefit Package for Radiology Package for MRI and CT Scans.

For any queries, contact us on  (020) 272 2527/56  benefitsandclaims@nhif.or.ke

This form is available on  www.nhif.or.ke