Children's℠
Healthcare of Atlanta

Radiology Precertification Services

Registration Sign-Up

The following information will expedite the precertification process. Thank you for choosing Children's Healthcare of Atlanta.

Physician's Practice Group Name: _____
Physician's Practice Address: _____
TAX ID Number: _____
Practice Manager Contact: _____
Direct Contact Number: _____
Contact Email Address: _____
Office Number: _____ **Fax Number:** _____

List of Physicians in Practice by Name and NPI Number:

Physician's Name	NPI Number

List of PAs or Nurse Practitioners:

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The Practice Group agrees to allow Children's to seek precertification for radiology procedures for its patients. By signing this agreement, the signatory represents and warrants that he/she is authorized to sign this document on behalf of the Practice Group and understands that the Practice Group is responsible for providing to Children's all clinical information needed to request and obtain authorization. The Practice Group further understands that Children's cannot guarantee that attempts to obtain precertification will be successful and services will not be provided without approved authorization. Finally, the Practice Group understands that Children's will not compensate the Practice Group, its physicians or employees in any way for referrals to Children's for radiology services.

Signature: _____

Email Completed Registration Form to radprecert@choa.org