

Central
Vein Care Specialists
Lakeland Vascular Institute
Kissimmee



Pablo Campus
Plant City Imaging
Women's Imaging Center
Vascular Specialists of Lakeland

Preauthorization Phone Line: 863-577-0299

Fax: (863) 581-8806

Date: _____

On behalf of _____ (Referring Provider), the undersigned entity hereby authorizes Radiology and Imaging Specialists of Lakeland (RIS) and Availity, LLC to utilize the Referring Physician's credentials in connection with the Authorization process through Availity's AuthPal & Outsourcing Process based on the Referring Provider's order and other information provided by the Referring Physician. Availity is an independent third party working for RIS.

Both RIS, Availity, LLC and Referring Provider expressly acknowledge and agree that this Agreement is NOT intended to induce or reward referrals of business. In furtherance of the foregoing, both parties also acknowledge and agree that NO purpose of this Agreement, or of either party's intent under this Agreement, is to induce or reward, directly or indirectly, referrals of Referring Provider business.

This agreement shall become effective no later than 2 weeks from _____ day of _____, 20____ and will continue until such time that Referring Provider, RIS and/or Availity choose to terminate this agreement in writing.

Referring Provider: (Please print legibly).

Practice: _____
Specialty: _____
Address: _____
Phone# _____
Fax #: _____
NPI Number: _____
Tax ID: _____
Name: _____
Title: _____

Provider Signature: _____

***Please Note: We must have most recent H&P, clinicals, patient demographics, and insurance information along with the exam order for us to initiate the preauthorization process on your behalf.**