ALLIANCE HEALTHCARE | RADIOLOGY

MRI Referral Form

5005 Whipple Avenue NW, Canton, OH 44718
Scheduling: **330.493.6747** | Fax: **602.773.3714**
Tax ID: **34-170771** | NPI: **1194733246**

PATIENT INFORMATION

[1] Patient Name _____ [2] Date of Birth _____ [3] Height _____ [4] Weight _____

[5] Patient Address _____ [6] Patient Telephone # _____ [7] Patient Mobile # _____

[8] Referring Provider _____ [9] Provider Telephone # _____ [10] Provider Fax# _____

AREA TO BE SCANNED: _____

Please Indicate: ☐ MRI ☐ MRA ☐ Other: _____

PRIMARY DIAGNOSIS: _____

_____

SIGNS AND SYMPTOMS: _____

_____

INS. CO.: _____ I.D. #: _____ Precert. #: _____

Date of Scan: _____ CPT Code used to obtain precert _____

CMS/APPROPRIATE USE CRITERIA (FOR MEDICARE PART B PATIENTS ONLY)

NPI#: _____

NAME OF CDSM CONSULTED (software used): _____

Determination Result (check one): ☐ 1) Adheres to ☐ 2) Does Not Adhere to ☐ 3) Not Applicable

☐ Without Contrast ☐ With Contrast ☐ Without & With Contrast

If no option is selected, the referring physician defers to the radiologist as to whether contrast is medically necessary.

Please **check the box** if the referring physician is willing to refer to the radiologist's judgment on whether the use of:

☐ Orbital X-rays are medically necessary

(The procedures may result in additional charges to the patient or insurance carrier, including government payers.)

[11] **Authorized Treating Provider's Signature:** (Stamps Not Accepted) _____ [12] **NPI #** _____ [13] **Date** _____

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