ALLIANCE HEALTHCARE | RADIOLOGY

Alliance HealthCare Radiology – West Des Moines
7601 Office Plaza Drive, Suite 115, West Des Moines, Iowa 50266
Scheduling: 515.222.0550 | Fax: 515.222.0544 | Tax ID: 26-0774863

PRE-AUTHORIZATION REQUESTED: ❑ Yes ❑ No
COPY OF INSURANCE CARD: ❑ Yes ❑ No
DEMOGRAPHIC SHEET: ❑ Yes ❑ No
CLINICAL NOTES: ❑ Yes ❑ No
PRIOR IMAGINING: ❑ Yes ❑ No

ULTRA HIGH-FIELD 3 TESLA MRI

ALL FIELDS MUST BE COMPLETED

Patient Name (First, Last): _____

Referring Physician Name (First, Last): _____

Patient Phone #: _____

Physician Phone #: _____

Date of Birth: _____

Physician Fax #: _____

Date of Office Visit: _____

Physician NPI: _____

Area To Be Scanned: _____

Please Indicate: ❑ MRI ❑ MR/Arthrogram ❑ Other: _____

Primary Diagnosis: _____

Signs/Symptoms (Required): _____

Ins. Co: _____ I.D. #_____ Precert. #:_____

Date of Scan: _____

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

NPI: _____ Name of CDSM Consulted (software used): _____

Determination Result (check one): ❑ Adheres to ❑ Does Not Adhere to ❑ Not Applicable

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Please check the following box(es) if the referring physician is willing to defer to the radiologist's judgment on whether the use of:

❑ Contrast is medically necessary ❑ Orbital x-rays are medically necessary

Please check the following box if the referring physician is ordering blood work for contrast patients when medically necessary:

❑ BUN, Creatinine and GFR level – Evaluation for Renal Function prior to MRI Contrast

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

Provider's Signature:* (Stamps Not Accepted)

_____ Date:_____

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