# MRI Request Worksheet

**MRI Insurance Coordinator**
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PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
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**Patient Name:** ..... Date of Birth: .....

Cell Phone: ..... Home Phone: .....

Primary Insurance Provider: ..... ID # .....

Secondary Insurance Provider: ..... ID # .....

Authorization #: ..... Verified By: .....

PLEASE INCLUDE YOUR **MOST RECENT CHART NOTES, PHYSICAL THERAPY NOTES, X-RAY REPORTS, DEMOGRAPHIC PAGE** AND **SIGNED DOCTOR'S ORDER**.

**MRI:** ..... CPT Code: .....

Diagnosis: .....

R/O: ..... ICD 10: .....

Notes:

.....

**Ordering Physician:** .....

NPI: ..... Tax ID: .....

Office Phone: ..... Office Contact: .....

Where would you like us to send your report? **Fax Number:** .....

*Patients will leave with a CD of their MRI images.*

Our **mission** is to provide high quality, accessible, and **affordable** MRI services for our patients in a **fast**, **friendly**, and **professional** manner.

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