

MRI ORDER FORM

LAST NAME		TODAYS DATE	*** ICD-10 INFO REQUIRED ***	
FIRST NAME		DATE OF BIRTH	NARRATIVE SYMPTOM OR DIAGNOSIS	
PHONE		ALT. PHONE	ICD-10 Code	
INSURANCE COMPANY				
POLICY #	GROUP #			
PHYSICIAN NAME		SPECIAL INSTRUCTIONS <input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT		
OFFICE TELEPHONE NUMBER				
PHYSICIAN SIGNATURE *** (REQUIRED)		PRE-AUTH REQUIRED: Y <input type="checkbox"/> N <input type="checkbox"/> PRE-AUTH #		

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	MRI ABDOMEN W/O & W DYE	74183
<input type="checkbox"/>	MRI ABDOMEN W/O & W DYE (KIDNEY PROTOCOL)	74183
<input type="checkbox"/>	MRI ABDOMEN W/O & W DYE (LIVER PROTOCOL)	74183
<input type="checkbox"/>	MRI ABDOMEN W/O & W DYE (MRCP PROTOCOL)	74183 76377
<input type="checkbox"/>	MRI ABDOMEN W/O DYE	74181
<input type="checkbox"/>	MRI ABDOMEN W/O DYE (ADRENAL PROTOCOL)	74181 76377
<input type="checkbox"/>	MRI ABDOMEN W/O DYE (MRCP PROTOCOL)	74181
<input type="checkbox"/>	MRI ANKLE LEFT W/O & W DYE	73723
<input type="checkbox"/>	MRI ANKLE LEFT W/O DYE	73721
<input type="checkbox"/>	MRI ANKLE RIGHT W/O & W DYE	73723
<input type="checkbox"/>	MRI ANKLE RIGHT W/O DYE	73721
<input type="checkbox"/>	MRI BRAIN W/O & W DYE	70553
<input type="checkbox"/>	MRI BRAIN W/O & W DYE (IAC PROTOCOL)	70553
<input type="checkbox"/>	MRI BRAIN W/O & W DYE (PITUITARY PROTOCOL)	70553
<input type="checkbox"/>	MRI BRAIN W/O DYE	70551
<input type="checkbox"/>	MRI BREAST BILATERAL W/O & W DYE	C8908
<input type="checkbox"/>	MRI BREAST BILATERAL W/O DYE	C8907
<input type="checkbox"/>	MRI BREAST UNILATERAL W/O & W DYE	C8905
<input type="checkbox"/>	MRI BREAST UNILATERAL W/O DYE	C8904
<input type="checkbox"/>	MRI CERVICAL SPINE W/O & W DYE	72156
<input type="checkbox"/>	MRI CERVICAL SPINE W/O DYE	72141
<input type="checkbox"/>	MRI CHEST W/O & W DYE	71552
<input type="checkbox"/>	MRI CHEST W/O DYE	71550
<input type="checkbox"/>	MRI ELBOW LEFT W/O & W DYE	73223
<input type="checkbox"/>	MRI ELBOW LEFT W/O DYE	73221
<input type="checkbox"/>	MRI ELBOW RIGHT W/O & W DYE	73223
<input type="checkbox"/>	MRI ELBOW RIGHT W/O DYE	73221
<input type="checkbox"/>	MRI FEMUR LEFT W/O & W DYE	73720
<input type="checkbox"/>	MRI FEMUR LEFT W/O DYE	73718

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	MRI FEMUR RIGHT W/O & W DYE	73720
<input type="checkbox"/>	MRI FEMUR RIGHT W/O DYE	73718
<input type="checkbox"/>	MRI FOOT LEFT W/O & W DYE	73720
<input type="checkbox"/>	MRI FOOT LEFT W/O DYE	73718
<input type="checkbox"/>	MRI FOOT RIGHT W/O & W DYE	73720
<input type="checkbox"/>	MRI FOOT RIGHT W/O DYE	73718
<input type="checkbox"/>	MRI FOREARM LEFT W/O & W DYE	73220
<input type="checkbox"/>	MRI FOREARM LEFT W/O DYE	73218
<input type="checkbox"/>	MRI FOREARM RIGHT W/O & W DYE	73220
<input type="checkbox"/>	MRI FOREARM RIGHT W/O DYE	73218
<input type="checkbox"/>	MRI HAND LEFT W/O & W DYE	73220
<input type="checkbox"/>	MRI HAND LEFT W/O DYE	73218
<input type="checkbox"/>	MRI HAND RIGHT W/O & W DYE	73220
<input type="checkbox"/>	MRI HAND RIGHT W/O DYE	73218
<input type="checkbox"/>	MRI HIP LEFT W/O & W DYE	73723
<input type="checkbox"/>	MRI HIP LEFT W/O DYE	73721
<input type="checkbox"/>	MRI HIP RIGHT W/O & W DYE	73723
<input type="checkbox"/>	MRI HIP RIGHT W/O DYE	73721
<input type="checkbox"/>	MRI HUMERUS LEFT W/O & W DYE	73220
<input type="checkbox"/>	MRI HUMERUS LEFT W/O DYE	73218
<input type="checkbox"/>	MRI HUMERUS RIGHT W/O & W DYE	73220
<input type="checkbox"/>	MRI HUMERUS RIGHT W/O DYE	73218
<input type="checkbox"/>	MRI KNEE LEFT W/O & W DYE	73723
<input type="checkbox"/>	MRI KNEE LEFT W/O DYE	73721
<input type="checkbox"/>	MRI KNEE RIGHT W/O & W DYE	73723
<input type="checkbox"/>	MRI KNEE RIGHT W/O DYE	73721
<input type="checkbox"/>	MRI LUMBAR SPINE W/O & W DYE	72158
<input type="checkbox"/>	MRI LUMBAR SPINE W/O DYE	72148
<input type="checkbox"/>	MRI ORBITS W/O & W DYE	70543
<input type="checkbox"/>	MRI ORBITS W/O DYE	70540
<input type="checkbox"/>	MRI PELVIS W/O & W DYE	72197

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	MRI PELVIS W/O & W DYE (UTERUS PROTOCOL)	72197
<input type="checkbox"/>	MRI PELVIS W/O DYE	72196
<input type="checkbox"/>	MRI SHOULDER LEFT W/O & W DYE	73223
<input type="checkbox"/>	MRI SHOULDER LEFT W/O DYE	73221
<input type="checkbox"/>	MRI SHOULDER RIGHT W/O & W DYE	73223
<input type="checkbox"/>	MRI SHOULDER RIGHT W/O DYE	73221
<input type="checkbox"/>	MRI SOFT TISSUE NECK W/O & W DYE	70543
<input type="checkbox"/>	MRI SOFT TISSUE NECK W/O DYE	70540
<input type="checkbox"/>	MRI THORACIC SPINE W/O & W DYE	72157
<input type="checkbox"/>	MRI THORACIC SPINE W/O DYE	72146
<input type="checkbox"/>	MRI TIBIA FIBULA LEFT W/O & W DYE	73720
<input type="checkbox"/>	MRI TIBIA FIBULA LEFT W/O DYE	73718
<input type="checkbox"/>	MRI TIBIA FIBULA RIGHT W/O & W DYE	73720
<input type="checkbox"/>	MRI TIBIA FIBULA RIGHT W/O DYE	73718
<input type="checkbox"/>	MRI WRIST LEFT W/O & W DYE	73223
<input type="checkbox"/>	MRI WRIST LEFT W/O DYE	73221
<input type="checkbox"/>	MRI WRIST RIGHT W/O & W DYE	73223
<input type="checkbox"/>	MRI WRIST RIGHT W/O DYE	73221
MRA/MRV		
<input type="checkbox"/>	MRA ABDOMEN W DYE	74185
<input type="checkbox"/>	MRA HEAD W/O DYE	70544
<input type="checkbox"/>	MRV HEAD W/O DYE	70544
<input type="checkbox"/>	MRA NECK W/O & W DYE	70549
<input type="checkbox"/>	MRA NECK W/O DYE	70547
OTHER EXAMS REQUESTED		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
** FOR MR ARTHROGRAM ORDERING PLEASE SEE FLUOROSCOPY ORDER FORM		

Fax this order to: (928) 532-1411 Scheduling Phone: (928) 537-6554 Radiology Dept Phone: (928) 537-6338



Acct# MR#
 Adm: DOB:
 Summit Healthcare Regional Medical Center

MRI ORDER FORM



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