Integra Medical Imaging
PHONE: 1.800.590.9MRI

TO ORDER MRI FAX OR EMAIL PRESCRIPTION TO:
859-757-2042 or scans@integradx.com

SCHEDULING FAX & PRESCRIPTION SHEET

PATIENT NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EMPLOYER/SCHOOL _____ ☐FT ☐PT

SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX ☐M ☐F ☐MARRIED ☐SINGLE

INSURANCE COMPANY _____ TYPE ☐PIP ☐MAJOR MEDICAL ☐MEDICARE ☐OTHER _____

TELEPHONE _____ ADJUSTER _____ PRIOR AUTH # _____ *(if applicable)*

CLAIM # _____ POLICY # _____ GROUP# _____

DATE OF INJURY *(if applicable)* _____ DATE OF FIRST DOCTOR CONSULTATION _____

INSURED _____ RELATIONSHIP _____ IF NOT SELF, THEN WHO _____

DATE OF BIRTH _____ SEX ☐M ☐F INS. PLAN _____ EMPLOYER/SCHOOL _____ POLICY GROUP # _____

ADDRESS WHERE CLAIMS ARE SENT _____

DEDUCTIBLE AMOUNT _____ MET? _____ % OF COVERAGE _____ BENEFITS EXHAUSTED? ☐Y ☐N

SECONDARY HEALTH INSURANCE _____

ADDRESS _____ TELEPHONE _____

ATTORNEY *(if applicable)* _____

ATTORNEY'S ADDRESS _____ ATTORNEY'S TELEPHONE # _____

PLEASE SPECIFY RIGHT, LEFT, OR BILATERAL MRI EXAM

SPINE	☐CERVICAL ☐THORACIC ☐LUMBAR ☐PELVIS
EXTREMITY *Circle* (L) *Left or* (R) *Right*	☐SHOULDER L / R ☐ELBOW L / R ☐WRIST L / R ☐KNEE L / R ☐ANKLE L / R ☐FOOT L / R
BODY	☐CHEST ☐ABDOMEN ☐OTHER
HEAD *(Brain)*	☐ROUTINE BRAIN ☐TMJ ☐SINUSES ☐ORBITS ☐PITUITARY ☐OTHER
SPECIAL INST.	☐CONTRAST ☐OTHER

DIAGNOSIS & MEDICAL NECESSITY _____

REFERRING PHYSICIAN _____ PHONE _____ FAX _____

PHYSICIAN'S SIGNATURE _____ LICENSE/UPIN# _____

APPOINTMENT DATE _____ APPOINTMENT TIME _____