MRI PRESCRIPTION FORM

□ W/C

Insurance Company: _____ Pre-authorization#: _____

Please include driver's license, insurance card(s), clinic notes, and any pre-authorization attained.

ORA Imaging Centers - IA 2300 53rd Avenue Bettendorf, IA 52722 Phone: 563.441.7608 Fax: 563.441.7646	ORA Imaging Centers – IA 6101 Northwest Blvd Davenport, IA 52806 Phone: 563.441.7608 Fax: 563.441.7646	ORA Imaging Centers - IL 520 Valley View Drive Moline, Il 61265 Phone: 309.757.8844 Fax: 309.757.8845	ORA Imaging Centers - IL 985 Avenue of the Cities Silvis, IL 61282 Phone: 309.865.2619 Fax: 309.865.2675

Patient's Name: _____

DOB: _____ Phone # _____ Alternative Phone # _____

MRI exam(s): _____

Diagnosis or Symptoms with ICD-10 Code: _____

_____

Additional Notes or Instructions: _____

MRI Appt Date & Time: _____

Ordering Physician: _____
(Physician Signature)

Ordering Physician: _____ NPI#: _____
(Physician Printed)

Physician's Phone #: _____ ***Physician's Fax #:*** _____