INSTRUCTIONS

- ❒ **Section 1** – Select appropriate anatomy
- ❒ **Section 2** – Select appropriate reason or diagnosis for study
- ❒ **Section 3** – Select imaging study modality (MRI, XRAY or CT) and correct scan type/views
- ❒ **Section 4** – Select appropriate procedure type
- ❒ **Step 5** – Fax or email this sheet for scheduling

EXPERTMRI

Technology | Science | Evidence

TEL: (877) 674-8888 | FAX: (877) 370-5458
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REQUEST FOR AUTHORIZATION

Patient Last Name _____
Patient First Name _____
Phone _____
Date of Injury _____
Date of Birth _____
Insurance Name (for PPO) _____
ID Number (for PPO) _____
❒ Cash ❒ WC ❒ Personal Injury ❒ PPO

LOCATIONS

❒ Bakersfield	❒ Culver City	❒ Lancaster	❒ San Bernardino	❒ Sun Valley	❒ Visalia
❒ Bellflower	❒ Downtown LA	❒ Mission Viejo	❒ San Diego	❒ Torrance	❒ Winnetka
❒ Beverly Hills	❒ Fullerton	❒ Riverside	❒ Sherman Oaks	❒ Tustin	

1. ANATOMY (PLEASE CIRCLE SELECTION)

Musculoskeletal	L	R		L	R
Shoulder	❒	❒	Femur	❒	❒
Humerus	❒	❒	Knee	❒	❒
Elbow	❒	❒	Tibia/Fibula	❒	❒
Forearm	❒	❒	Ankle	❒	❒
Wrist	❒	❒	Foot	❒	❒
Hand	❒	❒	TMJ	❒	❒
Hip	❒	❒			

Brain/Body	
Brain	❒
Brain with MR Angio	❒
Paranasal Sinuses	❒
Sella/Pituitary	❒
Orbits	❒
Neck Soft Tissue	❒

Spine	
Cervical	❒
Chest	❒
Lumbar	❒
Sacrum	❒
Sternum	❒
Thoracic	❒

Nerves	
Brachial Plexus	❒
Lumbosacral Plexus	❒
Sciatic Nerve	❒

2. REASONS

❒ Neck Pain	❒ Radiculopathy	❒ Extremity Pain	❒ Disc Bulge/Herniation	❒ Shoulder Injury
❒ Mid Back Pain	❒ Numbness/Tingling	❒ Post Surgery	❒ Facet Disease	❒ Knee Injury
❒ Low Back Pain	❒ Sprain/Strain	❒ Degenerative Disease	❒ Nerve Root Injury	❒ Other:_____

3. IMAGING STUDIES

MRI	
Complete Multi-positional Wt-Bearing MRI Upright, Full ROM Exam, 3 Views, OR Supine MRI with & without Wt-Bearing	❒
Single Position MRI	❒
Traumatic Brain Injury (TBI) Post Concussive Change; Diffusion Imaging of Brain	❒
Whiplash Protocol MRI Cervical and Craniocervical MRI	❒
Additional Notes:	

X-ray	
Standard views and as recommended by the AMA Guides, 5th Edition, for determining impairment (Please provide AiM Report if applicable to this body part)	❒

CT	
CT	❒

For a list of requirements or to order more pads, please scan this QR code or visit www.expertmri.com/requirements

4. PROCEDURE TYPE

❒ Motion Tracking Exam	❒ MRI Arthrogram	❒ Other: _____
❒ Right/Left Lateral Bending Studies	❒ I/V Contrast	_____
	❒ 4 or More Views	_____

PHYSICIAN NOTES

Email/Fax Report to _____

Referring Physician _____ Physician's Signature _____

Referring Facility Address _____ Telephone Number _____ Date _____