A1 MEDICAL IMAGING

A Consolidated Healthcare Company

YOUR APPOINTMENT

Date: ______________ Time: ______________

❑ **A1 Imaging of Aventura**
Ph: (305) 933-9565
Fax: (305) 933-8105

❑ **A1 Imaging of Ft. Lauderdale**
Ph: (954) 202-3400
Fax: (954) 202-3448

❑ **A1 Imaging of Deerfield Beach**
Ph: (954) 429-8381
Fax: (954) 429-2705

❑ **A1 Imaging of Pembroke Pines**
Ph: (954) 450-4020
Fax: (954) 432-8674

❑ **A1 Imaging of Plantation**
Ph: (954) 423-3674
Fax: (954) 916-0674

❑ **A1 Imaging of Cape Coral**
Ph: (239) 573-6333
Fax: (239) 573-8674

PATIENT INFORMATION

Patient Name: ________________________________ SS No.: ____________________

DOB: ____________ Home Tel.: ______________ Work Tel.: ______________ Cell: ______________

Patient Address: ____

INSURANCE INFORMATION

Primary Insurance Name: ______________________________ Tel. No.: ____________________

ID No.: ____________________ Group No.: ____________________ Auth. No.: ________________

Secondary Insurance: ______________________________ **Tel. No.:** ____________________

ID No.: ____________________ Group No.: ____________________ Auth. No.: ________________

Auto Insurance Name: ______________________________ Tel. No.: ____________________

Policy No.: ____________________ Claim No.: ____________________ Date of Accident: ______________

PHYSICIAN INFORMATION

Referring Physician: ______________________________________ Tel.: ____________________

Tax ID: ________________ NPI: ________________ Contact: ______________ Fax: ________________

❑ STAT- Call with Report ❑ Fax Report ❑ Send CD with Patient ❑ Send Films with Patient

Diagnosis and Special Instructions: ____

❑ The patient has a “emergency medical condition” (EMC) as defiened in Florida Motor Vehicle No-Fault Law, Florida Statutes Senctions 627.730-627.7405.

❑ Please determine if the patient has an “emergency medical condition” (EMC) as defined by the Florida Motor Vehicle No-Fault Law, Florida Statutes Sections 627.730-627.7405, and if the Patient does have an “emergency medical condition”, then please indicate on your Report. Attached is relevant Patient history.

Physician’s Signature: ______________________________________ Date: ________________

MRI / MRA PROCEDURE

HEAD / SPINE	WITHOUT CONTRAST	WITH CONTRAST
Brain	❑ 70551	❑ 70553
IAC’s		❑ 70553
Pituitary		❑ 70553
Orbits	❑ 70540	❑ 70543
Cervical Spine	❑ 72141	❑ 72156
Thoracic Spine	❑ 72146	❑ 72157
Lumbar Spine	❑ 72148	❑ 72158
BODY	**WITHOUT CONTRAST**	**WITH CONTRAST**
Neck / Soft Tissue	❑ 70540	❑ 70543
Brachial Plexus	❑ 73218	❑ 73220
Chest	❑ 71550	❑ 71552
Abdomen	❑ 74181	❑ 74183
Pelvis	❑ 72195	❑ 72197

MUSCULOSKELETAL	WITHOUT CONTRAST			
Shoulder	73221	❑ Right	❑ Left	❑ Bilateral
Elbow	73221	❑ Right	❑ Left	❑ Bilateral
Wrist	73221	❑ Right	❑ Left	❑ Bilateral
Hand	73218	❑ Right	❑ Left	❑ Bilateral
Hip	73721	❑ Right	❑ Left	❑ Bilateral
Femur	73718	❑ Right	❑ Left	❑ Bilateral
Knee	73721	❑ Right	❑ Left	❑ Bilateral
Lower Leg	73718	❑ Right	❑ Left	❑ Bilateral
Ankle	73721	❑ Right	❑ Left	❑ Bilateral
Foot	73718	❑ Right	❑ Left	❑ Bilateral

MR ANGIOGRAM	WITHOUT CONTRAST	WITH CONTRAST
MRA Head/COW	❑ 70544	❑ 70546
MRA Neck/Carotids	❑ 70547	❑ 70549

OTHER: CPT: