QUALITY CARE PARTNERS

**Authorization Request: MRI/MRA**

**Please Fax Request to: (740) 455-8817**

**Today's Date**: _____

**Member Information**

Member Name: _____DOB: _____

Member ID#: _____

**Ordering Physician Information**

Physician Name: _____Phone/Fax #: _____

Physician Address: _____

Physician Tax ID/NPI: _____Office Contact Person: _____

**Facility Information**

Facility Name: _____ Facility Tax ID/NPI: _____

Facility Address: _____ Facility Phone/Fax #: _____

Date of Service: _____

Diagnosis: _____

Diagnosis Code(s): _____

CPT Code(s): _____

Length of time for current pain occurrence: _____

Date of Most Recent Exam: _____

Exam Findings: (print legibly or attach office notes) _____

_____

4 Weeks of conservative treatment attempted with start date: _____

_____

If Spinal MRI Requested – Previous Surgery Levels Involved: _____

Other Testing/ Imaging Results: _____

_____