SOUTHWEST BONE & JOINT INSTITUTE
MRI REFERRAL FORM

PATIENT INFORMATION

Date: _____
Patient Name: _____
DOB: _____ SS# _____
Telephone #: (H) _____ (W) _____ (C) _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

PROCEDURE

UPPER EXTREMITY

MRI Procedure:	**Shoulder** _____ R/L	**Elbow** _____ R/L	**Wrist** _____ R/L	**Hand** _____ R/L
CPT:	73221 ☐	73221 ☐	73221 ☐	73218 ☐
ICD9:	RCT: 727.61 ☐	Lesion Ulnar Nerve 354.2 ☐	Ganglion 727.41 ☐	Pain in Hand 719.44 ☐
	Shoulder Impingement 726.2 ☐		Other: _____	

LOWER EXTREMITY

MRI Procedure:	**Knee** _____ R/L	**Ankle** _____ R/L	**Foot** _____ R/L
CPT:	73721 ☐	73721 ☐	73721 ☐
ICD9:	LMT 836.1 ☐ MMT 836.0 ☐	Pain in the Ankle 719.47 ☐	Pain in Foot 719.47 ☐
	ACL 844.2 ☐	Other: _____	

SPINE

MRI Procedure:	**C-Spine** _____	**L-Spine** _____	**T-Spine** _____
CPT:	72141 ☐	72148 ☐	72146 ☐
ICD9:	722.0 ☐ 722.4 ☐	722.52 ☐	722.51 ☐

AUTHORIZATIONS

Primary Auth: _____ Date: _____ Appr By: _____ Int:_____
Secondary Auth: _____ Date: _____ Appr By: _____ Int: _____
Patient Notified: _____ Date: _____ Appr By: _____ Int: _____
Date of Procedure: _____ Time: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

COMMENTS: _____

Please fax this form along with the most recent patient notes to: 575-534-0135