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—Joint Included

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

LOWER EXTREMITY—Joint Included

MRI Procedure:	**Knee** _____ R/L	**Ankle** _____ R/L	**Foot** _____ R/L	**Hip** _____ R/L
CPT:	73721	73721	73721	73721
ICD9:	LMT 836.1 ( ) MMT 836.0 ( )	Pain in the Ankle 719.47 ( )	Pain in Foot 719.47 ( )	Hip Pain 843.9 ( )
	ACL 844.2 ( )	Other: _____		

SPINE

MRI Procedure:	**C-Spine** _____	**L-Spine** _____
CPT:	72141	72148
ICD9:	722.0( ) 722.4 ( )	722.52 ( )

Upper Extremity—No Joint ____R/L
CPT: 73218 ICD9:_____

Lower Extremity—No Joint ____R/L
CPT: 73718 ICD9:_____

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: _____

External Providers: Please fax this completed referral form along with the latest patients notes to: 575-534-0135