ALLIANCE HEALTHCARE | RADIOLOGY

Alliance HealthCare Radiology – West Des Moines
7601 Office Plaza Drive, Suite 115, West Des Moines, Iowa 50266
Scheduling: 515.222.0550 | Fax: 515.222.0544 | Tax ID: 26-0774863

PRE-AUTHORIZATION REQUESTED:

❑ Yes*   ❑ No

ULTRA HIGH-FIELD 3 TESLA MRI

ALL FIELDS MUST BE COMPLETED

Patient Name (First, Last): ______________________

Referring Physician Name (First, Last): ______________________

Patient Phone #: ______________________

Physician Phone #: ______________________

Date of Birth: ______________________

Physician Fax #: ______________________

Date of Office Visit: ______________________

Physician NPI: ______________________

Area To Be Scanned: ______________________

Please Indicate: ❑ MRI ❑ MR/Arthrogram ❑ Other: ______________________

Primary Diagnosis: ______________________

Signs/Symptoms (Required): ______________________

Ins. Co: ______________________ **I.D. #** ______________________ **Precert. #:** ______________________

Date of Scan: ______________________

☐ Without Contrast ☐ With Contrast ☐ Without & With Contrast

If no option is selected, the referring physician defers to the radiologist as to whether contrast is medically necessary.

Please check the following box if the referring physician is ordering blood work for contrast patients when medically necessary:

❑ **BUN, Creatinine and GFR level – Evaluation for Renal Function prior to MRI Contrast**

(The procedures may result in additional charges to the patient or insurance carrier, including government payers)

Provider's Signature: (Stamps Not Accepted)

______________________ **Date:** ______________________

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*For pre-authorization requests, please attach the following: insurance information, order/working diagnosis, prior imaging, medical treatment, Tax ID and clinical notes.