For pre-certification, please call or fax:
Phone 207.883.3803
Fax 207.883.6348
If faxing an order, please include:
Demographics • Insurance Card • Clinical Notes

Appointment Date and Time		❍ Obtain Authorization ❍ Schedule Patient
Patient Name (as shown on insurance card)	Cell Phone	Home Phone
Patient DOB	Patient Height	Patient Weight
Insurance	Insurance ID #	
2nd Insurance	2nd Insurance ID #	
❍ Workers' Comp ❍ Auto	Date of Injury	Pre-certification # (if needed)

(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? ❍ No ❍ Yes **If yes,** ❍ Initial, ❍ Subsequent or ❍ Sequela

Medical Provider Signature Provider signature required. Do not use rubber stamp.	Date	Provider Phone
Medical Provider Name (print)	Practice Name	Provider Fax

REPORTING METHOD: ❍ **STAT: Fax Report** ❍ **STAT: Call Report (phone number to call:)**

MRI

Blood work results needed for patients over 60 years of age who are having a contrast study.
Blood work results also needed for patients who are diabetic, have lupus or kidney disease.

❍ **IV Contrast as clinically indicated by radiologist OR** ❍ **No Contrast**

NEURO
❍ Brain and/or ❍ Orbits
❍ IAC
❍ Pituitary
❍ Neck (Soft Tissue)
❍ TMJ
Spine
❍ Cervical ❍ Thoracic ❍ Lumbar
❍ Other ______

BODY
❍ Abdomen
❍ Pelvis
❍ MRCP w/3D Recons
❍ Chest
❍ Breast ❍ L ❍ R ❍ BIL

MSK
❍ Lower Extremity ❍ L ❍ R ❍ BIL
❍ Ankle
❍ Foot
❍ Hip/Pelvis
❍ Knee
❍ Pelvis/GYN Specify ______
❍ Tibia/Fibula
❍ Upper Extremity ❍ L ❍ R ❍ BIL
❍ Elbow
❍ Finger
❍ Forearm
❍ Hand
❍ Humerus
❍ Shoulder
❍ Wrist

OTHER
❍ X-ray to rule out metal
❍ Other ______

MRA
❍ Brain
❍ Abdomen (Aorta)
❍ Neck/Carotids
❍ Renal Arteries
❍ Upper Extremity ______ ❍ L ❍ R ❍ BIL
❍ Lower Extremity ______ ❍ L ❍ R ❍ BIL
❍ Other ______

CT

❍ **IV Contrast as clinically indicated by radiologist OR** ❍ **No Contrast**
❍ **3D Recons as clinically indicated by radiologist OR** ❍ **No 3D Recons**

NEURO
❍ Brain and/or ❍ Orbits
❍ IAC
❍ Pituitary
❍ Facial Bones
❍ Maxilla ❍ Mandible
❍ IAC/Temporal Bones
❍ Sinus
❍ Complete ❍ Limited
❍ Neck (Soft Tissue)
Spine
❍ Cervical ❍ Thoracic ❍ Lumbar

MSK
❍ Extremity ______
❍ L ❍ R ❍ BIL
❍ Arthrogram (if indicated)

BODY
❍ Chest ❍ Abdomen ❍ Pelvis
❍ Abdomen & Pelvis ❍ Urogram (IVP)
❍ Enterography ❍ Kidney Stone Protocol

TEMP BONES
❍ TMJ
❍ Mastoids

OTHER
❍ Other ______

CTA
❍ Brain ❍ Abdomen (Aorta)
❍ Neck/Carotids ❍ Renal Arteries
❍ Extremity ______ ❍ L ❍ R ❍ BIL

ABDOMEN CTA
❍ Adv Aorta
❍ Aorta-iliac Runoff

CHEST
❍ CTA to rule out Pulmonary Embolism
❍ High-resolution Lung
❍ Other ______