RAPA RADIOLOGY ASSOCIATES, P.A.

Imaging for Life

Radiology Associates, P.A.
Doctors Building Imaging Center
Suite 101
500 S. University
Little Rock, AR 72205
Scheduling: 501-686-2621
Fax: 501-614-7509

Date of Procedure

Arrival Time

IMPORTANT

If you cannot meet your appointment, please call 501-686-2621 24 hours in advance or as soon as possible.

RAPA accepts most major insurance plans, including Blue Cross Blue Shield products, Aetna, Cigna, United Health Care and QualChoice QCA. Prior authorization is required by most commercial insurance companies. Please preauthorize before scheduling procedure.

MRI/MRA REFERRAL FORM

Name of Patient _____ D.O.B./Age _____

Home Phone Number _____ Cell Phone Number _____

Diagnosis _____ Insurance Name _____

Referring Physician (Please Print) _____ Physician's Signature _____

Prior Authorization# _____ NPI# _____ Insurance Rep Name/Phone Number _____

CDSM HCPCS Code** _____ AUC Modifier** _____

Required for Medicare Payment Only

MRI

❑ Abdomen w/o Contrast 74181	❑ Extremity Lower w w/o Contrast 73720 Tib/Fib, Mid/Foreft, Femur, Foreft/Toes Left / Right	❑ Extremity Upper Joint 73221 w/o Contrast - Left / Right Shoulder, Elbow, Wrist, Finger	❑ Spine Cervical w/o Contrast 72141
❑ Abdomen w w/o Contrast 74183			❑ Spine Cervical w w/o Contrast 72156
❑ Brain w/o Contrast 70551	❑ Extremity Lower Joint 73721 w/o Contrast - Left / Right Knee, Ankle, Mid/Hindfoot, Hip	❑ Extremity Upper Joint 73223 w w/o Contrast - Left / Right Shoulder, Elbow, Wrist, Finger	❑ Spine Lumbar w/o Contrast 72148
❑ Brain w w/o Contrast 70553 Orbits/IACS/Pituitary			❑ Spine Lumbar w w/o Contrast 72158
	❑ Extremity Lower Joint 73723 w w/o Contrast - Left / Right Knee, Ankle, Mid/Hindfoot, Hip	❑ Soft Tissue Neck w/o Contrast 70540	❑ Spine Thoracic w/o Contrast 72146
❑ Bilat Breast MRI w w/o Contrast 77059		❑ Soft Tissue, Neck w w/o Contrast 70543	❑ Spine Thoracic w w/o Contrast 72157
❑ Extremity Upper w/o Contrast 73218 Scapula, Humerus, Forearm, Hand Left / Right	❑ MRI Extremity Lower 73718 w/o Contrast - Left / Right Tib/Fib, Mid/Foreft, Femur, Foreft/Toes	❑ Pelivs w/o Contrast 72195	❑ Other: _____ Left / Right, Bilat, w/o, w & w/o
		❑ Pelivs w w/o Contrast 72197	
❑ Extremity Upper w w/o Contrast 73220 Scapula, Humerus, Forearm, Hand Left / Right	❑ MR/Arthrogram 73222 Shoulder **OR** Wrist **OR** Elbow Left / Right	❑ MR/Arthrogram 73722 Hip **OR** Knee - Left / Right	

MRA

❑ Head w/o Contrast COW 70544	❑ Head w w/o Contrast MRV 70546	❑ Neck w/o Contrast 70547	❑ Neck w w/o Contrast 70549

Fax order to 501-614-7509

MAGNETIC RESONANCE IMAGING - MRI

Please answer the following questions prior to scheduling a patient.

The following items can interfere with the MRI study. Some can be hazardous to the patient's safety. Carefully check the appropriate box for each item listed below:

❑ Yes ❑ No Claustrophobia (sedation required)
❑ Yes ❑ No Allergies _____
❑ Yes ❑ No Cardiac (Heart) Pacemaker
❑ Yes ❑ No Implanted Electrodes or Electrical Devices
❑ Yes ❑ No **Pumps (Infusion, Insulin, Chemotherapy)***
❑ Yes ❑ No **Aneurysm Clip or Surgery***
❑ Yes ❑ No Prior Brain Surgery
❑ Yes ❑ No Prior Vascular Surgery
❑ Yes ❑ No Prior Lumbar Spine Surgery
❑ Yes ❑ No War Injury or Gunshot Wound
❑ Yes ❑ No Metal Worker or Possible Metal Fragments in head, eye or body (e.g. welders, machinists)
❑ Yes ❑ No Metal rod, pin, screw or orthopedic (bone) device
❑ Yes ❑ No **Middle Ear Prosthesis (Cochlear Implant)***
❑ Yes ❑ No **Prosthetic Heart Valve***
❑ Yes ❑ No Sickle Cell Anemia, Renal dz (specify)
❑ Yes ❑ No Known or possible pregnancy
❑ Yes ❑ No Breast Feeding
❑ Yes ❑ No Patient Weight _____ lbs.

If the response to any of the above questions is "yes," please contact the imaging center for further consultation prior to the appointment. **(*) Please bring medical ID card to appointment.**

Previous X-rays; CT; or MRI: ❑ Yes ❑ No ❑ Patient to bring ❑ Will send by courier

I authorize Radiology Associates, P.A. to perform the requested procedure and/or other procedures, as needed, based on the radiologists' professional judgement. I have reviewed the above information and affirm it to be correct to the best of my knowledge.

Patient Signature/Date _____ Witness Signature/Date _____