MAYFIELD
IMAGING CENTER

PATIENT REFERRAL & INSURANCE PRE-CERTIFICATION FORM

FAX to 859-341-1983 **Office phone 513-569-5200**

MRI appointment date _____ **time** _____

Date_____ **Patient Name**_____
Last First

Address _____
Street City State Zip

SS# _____Date of Birth _____Work phone (_____)_____

Home phone (_____)_____

Referring Physician_____Phone_____Fax _____

Contact person _____Exam ordered_____

Date of onset _____R/O Primary Diagnosis _____

❑ Surgical review ❑ Stat Read

History, reason for service (include all pertinent symptoms and duration)

Please provide any clinical information or complete below:

Symptoms and previous diagnostic tests (for this condition)_____

_____

_____

_____

Insurance

Faxing front and back of patient's insurance card: ❑ yes ❑ no

If no, complete the following information:

Insurance Co. _____Responsible party _____

ID# _____Group #_____

Final authorization

Approved: ❑ yes ❑ no

Approval number _____Approved by _____Phone _____

Referring physician signature _____