For Authorization and Billing purposes use:
Coeur d'Alene Spine and Brain
Tax ID# 57-1155831

3320 N. Grand Mill Lane
Coeur d'Alene, ID 83814
Phone (208) 765-1770
FAX (208) 292-3177

PLEASE PRINT THE FOLLOWING INFORMATION

Patient name: ____________________ Date of birth: __________SS#: ____-___-_____

Home phone: ______________ Work phone: ______________ Cell: ______________

Address: ____

Insurance information: (Please FAX front and back of insurance card)

Primary insurance: ______________ Policy #: ______________ Group #: ____________

Secondary insurance: ______________ Policy #: ______________ Group #: ____________

☐ MRI

BRAIN
- ☐Routine
- ☐TMJ
- ☐Posteria Fossa
- ☐Sinuses
- ☐LAC's
- ☐Pituitary
- ☐Orbits

SPINE
- ☐Cervical
- ☐Thoracic
- ☐Lumbosacral

JOINTS
- Shoulder ☐L ☐R
- Elbow ☐L ☐R
- Wrist ☐L ☐R
- Hip ☐L ☐R
- Knee ☐L ☐R
- Ankle ☐L ☐R

OTHER
- ☐Abdomen
- ☐Pelvis
- ☐Prostate

☐ MRA

- ☐Circle of Willis
- ☐Carotid Arteries
- ☐Vertical Arteries

IF REQUESTING SPECIALTY IMAGES, PLEASE INDICATE HERE

CERVICAL
- ☐Neutral
- ☐Flexion
- ☐Extension
- ☐Lateral Bending
  - ☐Left
  - ☐Right

LUMBOSACRAL
- ☐Neutral
- ☐Flexion
- ☐Extension
- ☐Lateral Bending
  - ☐Left
  - ☐Right

☐ **OTHER**

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• **MRI IV contrast** is indicated in the following circumstances: post surgical spine, r/o infectious process, spinal cord syrinx and r/o cancer or tumor.

Please specify: with contrast? YES NO

Please specify ICD-9 & Signs & Systems: (Do not use Rule Out, Probable, Possible, Suspected or Routine):

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____
____

Physician's Name: ______________ Signature: X ______________________

Phone: ______________ Fax: ______________________