18501 Pines Blvd
Ste 205-B
Phone: 954-278-9088
Fax: 954-607-5825
Email: info@logicdinc.com

PATIENT INFORMATION

Name:_____ SS#_____

Address:_____

DOB:_____ Sex: □ M □ F

INSURANCE INFORMATION

Name of Insurance:_____ ID_____

Name Insured:_____ Group_____

Claim No_____ Auth:_____

REFERING PHYSICIAN INFORMATION

Name of Clinic:_____

Ph#_____ Fax#_____ Contact:_____

Diagnosis:_____

MRI/MRA & CARDIAC STUDIES

□ **BRAIN W/O 70551**	□**CERVICAL W/O 72141**	□ **BRACHIAL PLEXUS W/O 71550**
□ **BRAIN W & W/O 70553**	□ **CERVICAL W & W/O 72156**	□ **BRACHIAL PLEXUS W & W/O 71552**
□ **IAC W & W/O 70553**	□ **LUMBAR W/O 72148**	□ **PELVIS-SOFT TISSUE W/O 72195**
□ **NECK SOFT TISSUE W/O 70540**	□ **LUMBAR W & W/O 72158**	□ **PELVIS-SOFT TISSUE W 72197**
□ **NECK SOFT TISSUE W&W/O 70543**	□ **THORACIC W/O 72146**	□ **OTHER MRI _____**
□ **ORBIT W & W/O 70543**	□ **THORACIC W & W/O 72157**	□ **OTHER MRA _____**
□ **PITUITARY W & W/O 70553**	□ **ABDOMEN W/O 74181**	□ **Electrocardiogram w/ Interprettion & Report 93000**
□ **TMJ RT LT 70336**	□ **ABDOMEN W & W/O 74183**	□ **Holter Monitor 24 hrs 93224**

Name of Physician_____ Signature_____ Date_____