



APPROVAL

Attorney: _____

Patient: _____

Fax: (____) ____-____

Phone: (____) ____-____

Email: _____

Physician: _____

PLEASE SEE THE ATTACHED ORDERS AND LISTED COST. PLEASE CALL THE OFFICE IF YOU HAVE ANY QUESTIONS OR TO SCHEDULE THE MRI'S REQUESTED.

**IN-NETWORK
NO DEPOSIT**

**OUT-OF-NETWORK
\$200 DEPOSIT**

APPROVED	DECLINED			
<input type="checkbox"/>	<input type="checkbox"/>	CERVICAL		\$695
<input type="checkbox"/>	<input type="checkbox"/>	LUMBAR		\$695
<input type="checkbox"/>	<input type="checkbox"/>	SHOULDER	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	ELBOW	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	WRIST	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	HIP	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	KNEE	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	ANKLE	(R) OR (L)	\$695 OR \$1390
<input type="checkbox"/>	<input type="checkbox"/>	BRAIN		\$695
<input type="checkbox"/>	<input type="checkbox"/>	OTHER	(R) OR (L)	\$695 OR \$1390

FOR MRI'S WITH CONTRAST PLEASE CONTACT OUR OFFICE FOR PRICING

A 24-HOUR CANCELLATION NOTICE MUST BE GIVEN TO AVOID \$150 NO SHOW FEE

PLEASE FAX OR EMAIL ALL REQUIRED PAPERWORK
(REFERRAL AND APPROVAL)

COURTNEYH@LAMRIINC.NET

SAMANTHAH@LAMRIINC.NET

ATTORNEY SIGNATURE _____

DATE: _____