HEALTH AMERICA
HEALTHASSURANCE
Coventry Health Care Plans

MRI Worksheet

Date:	Attention:	
Member Name:	Member ID Number:	Date of Birth:
Requesting or Ordering Provider Name:	Tax ID or Provider ID Number:	
Contact Name (Provider's Office):	Contact's Telephone Number :	Contact's Fax Number:
Facility Where Study is To Be Performed:	Proposed Date of Service:	
Suspected Diagnosis:	Reason for MRI:	

LOCATION (place a in appropriate box(es))

Knee	**Shoulder**	**Ankle**	**Wrist**	**Hip**
Cervical Spine	**Thoracic Spine**	**Lumbar Spine**	**Other (specify):** _____	

Symptoms/Chief Complaint: (e.g. locking, joint pain, weakness and numbness of arm etc.)

Symptom	Duration

Physical Findings (e.g. blood in joint, pain with passive range of motion, etc.)

Medications

Name	Frequency	Duration

Tests, Procedures, Lab, Xray results

Type of Study	Date of Study	Result

Activity Modifications (e.g. bedrest, no lifting, etc.)

Type	Duration	Outcome

Treatments (e.g. ice, heat, physical therapy, etc.)

Type	Frequency	Duration	Outcome

Symptoms continue after treatments listed above have been tried

Other Pertinent Information:

FAX TO: 1-888-247-4791