# MRI / CT Expedite Form

Phone: 1 866 899 4674 Fax: 1 866 307 1247

Nurse Consultant: ________________ Phone Number: _________________

Worker's Name: ________________________________________________________

DOB: _____________________________ Claim #: __________________________

Phone Number: ___________________

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Type of Scan: MRI ☐ CT ☐

Area of Scan (s): ________________________________________________________

Approval Memo #: ___________________

Hospital Expediting To/City Worker Lives: _________________________________

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Referring Physician: Dr. _________________________________

Phone: _____________________________________________

Date & Location of scan currently (if known):

_________________________________________________ Does not apply ☐

Additional Info: ________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

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