Quote Award

MedicalServiceQuotes.com
INTELLIGENT HEALTHCARE.

Request ID	Type	Claim Number:
	Diagnostics	Claim Payer:
		Employer:
Date Service Required:		Date Awarded:

Company:	**Provider:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**

Patient Information:

First Name:	**SSN:**
Last Name:	**Primary Phone:**
Address:	**Alternate Phone:**
City & State:	**Date of Birth:**
Date of Injury:	**Date Services Needed:**
Employer:	
Diagnosis:	**ICD10:**

Physician Information:

Name:	**Address:**
City:	**State:**
Zip:	**Phone:**

Adjuster Information:

Name:	
Email:	
Phone:	

Case Manager Information:

Name:	
Email:	
Phone:	

Exam Type	CPT	Qty	Amount
MRI w/o Contrast	72148	1.0000	

Payer Notes: MRI LUMBAR SPINE W/O CONTRAST-72148-: If your facility is greater than 30 miles from the claimant zip code, please state this in your notes. Claimant is required to receive a disk of completed report at the time of the appointment. Once completed, email a copy of the report to at Include the claim # in the subject line of all emails

Provider Notes: