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: ___________________   Date of Loss:_____________________

Employer Name____

Type of Scan: MRI ☐ CT ☐

Area of Scan (s): ____

Approval Memo #: ___________________

Hospital Expediting To/City Worker Lives: _________________________________

Referring Physician: Dr. _________________________________

Phone: ____

Date & Location of scan currently (if known):

____ Does not apply ☐

Additional Info: ____

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Fax To: **1 866 307 1247**