PRIOR AUTHORIZATION
P: 413.781.9000
F: 413.781.7988

If faxing an order, please include:
- Demographics
- Insurance card
- Clinical notes

HOURS OF OPERATION
Mon - Fri 7 a.m. - 11 p.m.
Sat, Sun 8 a.m. - 6 p.m.

WALK-IN X-RAY*
Mon - Fri 8:30 a.m. - 4 p.m.
**To confirm availability, call in advance.*

SPRINGFIELD
3640 Main St., Suite 101
Springfield, MA 01107

RAYUS RADIOLOGY™

Appointment date and time	Check-in time	Patient DOB	O M O F
Patient name (as shown on insurance card)	Primary phone #	Secondary phone #	
Patient address			
O Auto O Workers' comp O Commercial/Private	Date of injury	Insurance name	Insurance ID # / Authorization #

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? O No O Yes **If yes** O Initial O Subsequent or O Sequela

Clinical Decision Support (CDS)
Required for Medicare Part B

Modifier (determination)	G-code (vendor)

MRI

O IV contrast as clinically indicated by radiologist OR O No contrast

EQUIPMENT PREFERENCE
O High-field open MRI
O 3T MRI
O No preference

NEURO
O Brain and/or O Orbits
- O IAC
- O Pituitary

O Volumetric brain imaging (NeuroQuant®) - What are you looking to measure? _____

Spine
- O Cervical
- O Thoracic
- O Lumbar

O Sacrum coccyx
O Neck (soft tissue)
O Brachial plexus

MUSCULOSKELETAL
O Extremity _____
O L O R O BIL
O Joint _____
O L O R O BIL O Arthrograms (w/Gadolinium)
O TMJ bilateral

BODY
O Abdomen
O MRCP w/3D reconstruction
O Pelvis
O Chest
O Enterography (abdomen/pelvis)

MRA
O Brain
O Neck/Carotids
O Arch
O Renal arteries
O Aorta
O Extremity _____
O L O R O BIL

OTHER
O _____

CT

O IV contrast as clinically indicated by radiologist OR O No contrast

O 3D reconstruction as clinically indicated by radiologist OR O No 3D reconstruction

NEURO
O Brain
- O IAC
- O Pituitary
- O Orbits

Spine
- O Cervical
- O Thoracic
- O Lumbar

O Sinus
O Temporal bones
O Facial bones
O Neck (soft tissue)

MUSCULOSKELETAL
O Extremity non-joint _____
O L O R O BIL
O Extremity joint _____
O L O R O BIL O Arthrograms

BODY
O Abdomen
O Pelvis
O Abdomen & pelvis
O Chest
O Urogram (abdomen/pelvis)
O Enterography (abdomen/pelvis)
O Kidney stone (abdomen/pelvis)

CTA
O Brain
O Chest
O Neck/Carotids
O Renal arteries
O Aorta
O Extremity _____
O L O R O BIL

OTHER
O _____

ULTRASOUND

O Doppler as clinically indicated by radiologist OR O No Doppler

O Transvaginal as clinically indicated by radiologist OR O No transvaginal

O Abdomen O Complete O Limited
O Aorta
O Aorta aneurysm screening
O Renal
O Bladder
O Pelvis O Complete O Limited
O Pelvis/Transvaginal
O Scrotum/Doppler
O Soft tissue abdomen
O Thyroid
O Vascular studies
- O Carotid O L O R O BIL
- O Venous leg O L O R O BIL
- O Venous arm O L O R O BIL

O Non-vascular extremity _____
O L O R O BIL
O Other _____

X-RAY

Views _____
O Chest
O Abdomen (KUB)
O Spine
- O Cervical
- O Thoracic
- O Lumbar

O Extremity _____
O L O R O BIL
O Orbits screening pre-MRI
O Other _____

ARTHROGRAMS/DTI

(Dedham, Peabody & Springfield only)

O Arthrograms **O DTI**
O L O R O BIL

O Shoulder
O Knee
O Hip

REPORTING METHOD
O Report only O Report & CD O Web viewing O Phone report _____ O Fax report _____

Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required) Do not use rubber stamp.	**NPI # (required for new providers)**	Date

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RAYUS RADIOLOGY™

PATIENT PREPARATION

MRI
Please inform us if you have a pacemaker, cardiac defibrillator, ICD, cochlear ear implants or severe renal disease, are on dialysis, have had an injury to your eyes with metal or have any metal objects in your body.

CT

Procedures with IV contrast:
No food two (2) hours prior to your procedure. Inform the office if you have kidney disease, are on dialysis or are taking medications. Drink plenty of liquids the day prior to the exam and water up to exam time for hydration.

Procedures without contrast:
No preparations are required.

ORAL CT CONTRAST
Do not eat or drink anything for two (2) hours prior to your exam (with the exception of the oral contrast). We recommend you hydrate with water up to the time of your appointment for your benefit.

Your medications may be taken with water.

ULTRASOUND

Abdomen (includes gallbladder, liver, pancreas, spleen, biliary tract, common bile duct, kidneys and aorta)
Nothing to eat or drink six (6) hours prior to examination. Prescription medication may be taken with a small amount of water.

Pelvic/Urinary bladder

a. One and one half (1½) hours before the exam is scheduled, drink 32 oz. of fluid (water, tea, coffee, etc.). No orange juice, milk or carbonated beverages.

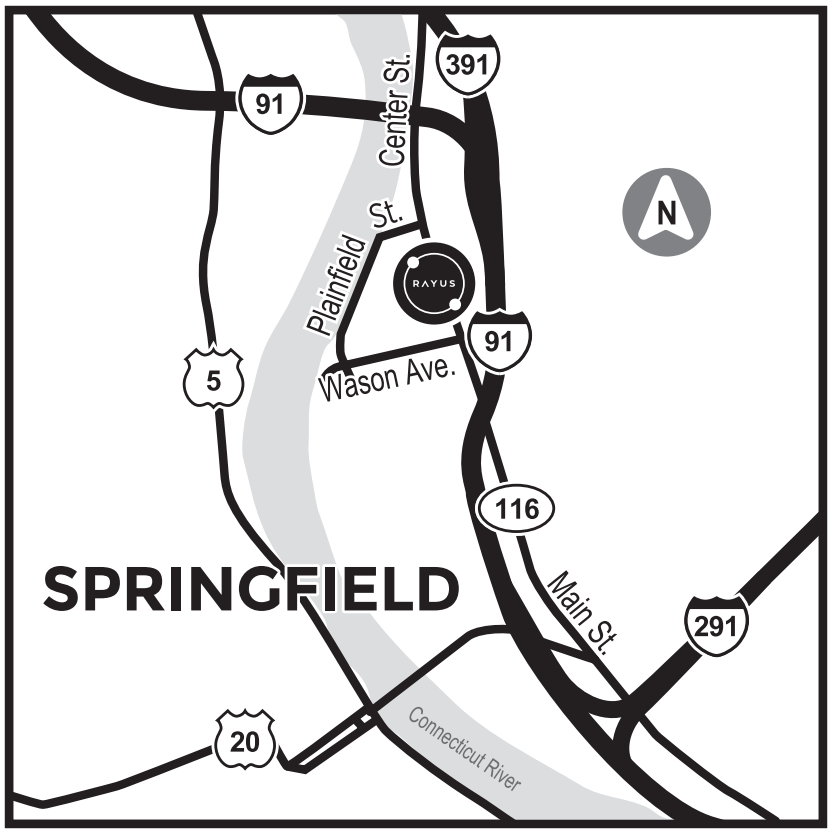
b. You should finish drinking one (1) hour before exam time.

c. **Do not empty bladder** one (1) hour before (this study requires that your bladder be full. This may result in an uncomfortable feeling).

d. You may eat and drink up to one (1) hour before exam time.

X-RAY
No preparations are required.

SPECIAL INSTRUCTIONS
Patient should bring any CDs related to the imaging procedure to be performed. Any sedation or pain medication for a procedure must be prescribed by the patient's provider. Inform the office if you are or may be **pregnant** or are a **nursing mother**.



SPRINGFIELD
3640 Main St., Suite 101
Springfield, MA 01107

LEGAL NAME
Chelmsford MRI PC

TAX ID 04-3133041

NPI 1386662112*
**For Medicaid, Medicare, RR Medicare and Medicare Crossover Claims to BCBS, use NPI 1821435553.*

FROM THE NORTH - ROUTE 91S TO EXIT 8:
- Make a right at the end of the exit onto Birnie Ave.
- At the end of the street, make a right onto Wason Ave.
- Proceed to the end of the street, make a left onto Main St.
- The center is on the left at 3640 Main St.
- The center is located on the first floor, Suite 101

FROM THE SOUTH - ROUTE 91N TO EXIT 8:
- Make a left off the ramp at the light onto Main St.
- The center is on the left at 3640 Main St.
- The center is located on the first floor, Suite 101