INSURANCE WORK SHEET

NorthwestMRI

Fast. Friendly. Affordable. Professional Service.

Date:

Patient Name: DOB:

Patient Phone:

PIP/MVA:

Adjustor: Injury Date:

Claim Number:

CLAIM SUBMISSION:

Authorization Required: Yes: ☐ No: ☐

Authorization Started: Yes: ☐ No: ☐

Subscriber: DOB:

Insuance Name:

Insurance Address:

City: State: Zip:

Phone: Fax:

ID#: Group #:

QUOTE: **Tax ID: 26-4367483** **NPI: 1891057493**

Exam: CPT: ICD.9

Deductible Amout IN Network: OUT Network:

Amount of Deductible MET:

C0-Insurance % IN Network: OUT Network:

Patients Responcibility: **$**

Reimbersment Amount: **$**

Comments: