PHYSICIAN REVIEW FORM

Please complete only if you are the Physician requesting **New MRI(s)** for the applicant. You do not need to complete this step if the applicant is requesting payment for **Past MRI(s)**.

Physician Name: _____ Physician Phone: _____

Physician Address: _____

Physician Email: _____ Patient Name: _____

Patient Date of Birth: _____

1. Based on my examination and/or review of medical records, the above-mentioned patient:

   □ Exhibits symptom(s) that may indicate a diagnosis of multiple sclerosis
   OR
   □ Has a diagnosis of multiple sclerosis

2. To help either confirm a diagnosis of MS or evaluate current MS disease progression, the above-mentioned patient requires a:

   □ Cranial (brain) MRI □ C-Spine MRI □ Both Cranial & C-Spine MRIs

3. I, or a close family member, have a financial or compensation arrangement with, or ownership interest in, an imaging center or hospital with an MRI machine.

   □ Yes □ No

   If yes, please provide the facility name and address:

   _____

□ Yes, I hereby certify that the above information provided to MSAA is accurate to the best of my knowledge. I have received the above-mentioned patient's permission to release such statements regarding his or her treatment and/or diagnosis.

Physician Signature: _____Date: _____

If approved, please coordinate with your doctor to have your MRI script faxed to the imaging center that will perform your MRI(s).

Courtney Blewett, Manager of Mission Delivery – MRI
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