1250 South Washington St.
Van Wert, Ohio 45891

Medical Imaging PrePay Program

PLEASE PRINT INFORMATION:

Name:_____ Social Security No:_____

(Last) (First) (MI) Date of Birth:_____

Diagnosis:_____ Sex: M F

_____ Phone Number: _____

_____ Date ordered:_____

Ordering Physician: _____

MARK THE MRI TESTS NEEDED:

ALL PRICING INCLUDES PHYSICIAN READ FEES

This Procedure Must be scheduled through Van Wert County Hospital Central Scheduling at 419-238-8642.
Please fax this order to 419-238-8617 when scheduling appointment.

MRI Head:
____ {$650} Without contrast
____ {$700} With contrast
____ {$750} With and without contrast

MRI Spine:
____ {$650} Without contrast
____ {$700} With contrast
____ {$750} With and without contrast

MRI Abdomen:
____ {$650} Without contrast
____ {$700} With contrast
____ {$750} With and without contrast

MRI Extremity:
Specify:_____
____ {$650} Without contrast
____ {$700} With contrast
____ {$750} With and without contrast

MRI Other:
Specify:_____
____ {$650} Without contrast
____ {$700} With contrast
____ {$750} With and without contrast

_____ Total

Disclaimer:
Any test performed with the Medical Imaging PrePay Program will NOT have a preauthorization performed through insurance companies and is NOT eligible to be applied to your deductible.

_____ _____
Ordering Physician's signature Date