SPIN Specialty Provider Imaging Network
Radiology Solutions through Technology

Phone: 516.331.5210
Fax: 516.345.9740

Radiology Order Form

Submitter Details

Submitted By: ☐Adjuster ☐Provider ☐Case Mgr ☐Patient ☐Other

Patient Details

First Name:		Last name:	
Address1:		Address2:	
City:		State	
Zip:		Home Phone:	( ) -
Work Phone:	( ) -	Other Phone:	( ) -
Social Sec #:	- -	Gender:	☐Male ☐Female
Claim #:		Date of Injury:	/ /
Employer:		Emp Phone:	( ) -

Insurance Details

Insurance Carrier:					
Address1:		Address2:			
City:		State:		**Zip:**	
Adjuster Name:		Adjuster Email:			
Adjuster Phone:	( ) -	Adjuster Fax:	( ) -		

Referring Physician Details

First Name:		Last name:	
Address1:		Address2:	
City:		State	
Zip:		Office Phone:	( ) -
Office Fax:	( ) -	Email:	

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Procedure Details

Study:	☐MRI	☐CT	☐Nuclear Med	☐Fluoroscopy	☐Other
Body Part:	☐Spine	☐Extremities	☐Chest	☐Head	☐Other
Contrast:	☐Without	☐With	☐With & Without		
Laterality:	☐Left	☐Right	☐ N/A		

Diagnosis / Rule Out:

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Other Details

Notes / Comments:

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*** Please note - if order be being faxed, the order script from referring provider must be attached.**