



PATIENTS: CALL TO MAKE AN APPOINTMENT TAKE A CELL PHONE PHOTO OF THIS FORM AND TEXT OR EMAIL IT TO RX@ZPRAD.COM

Physician *Letter of Medical Necessity*

Please be advised that _____ is presently
Patient Name Date of Birth
being treated under my care. I find the test indicated below to be medically necessary.

Clinical Indications/Signs/Symptoms

Vikas Varma, MD

164-08 65th Avenue, Fresh Meadows NY 11365 • T: (718) 460-1111 • F: (718) 460- 5111

Signature (required):

NEUROLOGICAL IMAGING

☐ **CT**

- ☐ With Contrast ☐ Without Contrast
☐ With & Without Contrast ☐ Oral Contrast Only
☐ IV Contrast Only ☐ Oral & IV Contrast

CT Angiography

- ☐ Coronary artery CTA with calcium scoring (needs contrast)
☐ CT angiogram (needs contrast)
☐ Intracranial ☐ Carotid
☐ Circle of Willis

Neuro/ENT

- ☐ Brain ☐ Orbits
☐ Temporal bones ☐ Paranasal sinuses
☐ Soft tissues neck
☐ Other:

☐ **MRI/PET** ☐ Add I.V. MRI contrast if needed

PET Only Auth#:

- ☐ 78608 Brain
☐ Other:

☐ **With additional MRI** Body region: _____

MRI Auth#: _____

☐ **PET/CT** ☐ Add I.V. CT contrast if needed

☐ PET/CT Auth#:

- ☐ 78814 Brain
☐ Other:

☐ **Nuclear Medicine**

☐ Specify

☐ **MRI**

- ☐ 3T Wide-Bore ☐ 1.5T Wide-Bore ☐ 1.2 Open-Sided
☐ Either 3T or 1.5T Wide-Bore

☐ With & without contrast ☐ No contrast

☐ With I.V. sedation

Neuro/ENT/Spine

- ☐ Brain
☐ Orbits
☐ Pituitary
☐ IAC
☐ Cervical spine
☐ Thoracic spine
Specify level of pathology _____

- ☐ Lumbar spine
☐ Sacrum/coccyx
☐ CSF Flow
☐ DTI
☐ Perfusion
☐ MR spectroscopy
☐ TMJ
☐ Soft tissue neck/parotid
☐ Other _____

MRA

- ☐ Carotid MRA
☐ Intracran/ circle of Willis
☐ Intracran/ MR venogram
☐ Carotid
☐ Aortic arch

☐ Other _____

☐ **Digital X-ray**

Region:

☐ **Ultrasound**

☐ Carotid Doppler ☐ Other:



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	ELMHURST	88-12 Queens Blvd, 11373	(718) 684-7427
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