

X-RAY ORDER FORM

LAST NAME		TODAYS DATE	*** ICD-10 INFO REQUIRED ***	
FIRST NAME		DATE OF BIRTH	NARRATIVE SYMPTOM OR DIAGNOSIS	
PHONE		ALT. PHONE	ICD-10 Code	
INSURANCE COMPANY		1		
POLICY #		2		
GROUP #		3		
PHYSICIAN NAME		SPECIAL INSTRUCTIONS		
OFFICE TELEPHONE NUMBER		<input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT		
PHYSICIAN SIGNATURE *** (REQUIRED)		PRE-AUTH REQUIRED: Y <input type="checkbox"/> N <input type="checkbox"/> PRE-AUTH #		

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	XRAY ABDOMEN ACUTE SERIES	74022
<input type="checkbox"/>	XRAY ABDOMEN 1 VIEW	74030
<input type="checkbox"/>	XRAY ABDOMEN SUPINE & ERECT VIEWS	74020
<input type="checkbox"/>	XRAY AC JOINTS BILATERAL W/O OR W WEIGHTS	73050
<input type="checkbox"/>	XRAY ANKLE LEFT 2 VIEWS	73800
<input type="checkbox"/>	XRAY ANKLE LEFT MINIMUM 3 VIEWS	73810
<input type="checkbox"/>	XRAY ANKLE RIGHT 2 VIEWS	73800
<input type="checkbox"/>	XRAY ANKLE RIGHT MINIMUM 3 VIEWS	73810
<input type="checkbox"/>	XRAY BONE AGE STUDY	77072
<input type="checkbox"/>	XRAY BONE LENGTH STUDY	77073
<input type="checkbox"/>	XRAY CALCANEUS LEFT MINIMUM 2 VIEWS	73850
<input type="checkbox"/>	XRAY CALCANEUS RIGHT MINIMUM 2 VIEWS	73850
<input type="checkbox"/>	XRAY CERVICAL SPINE 2 OR 3 VIEWS	72040
<input type="checkbox"/>	XRAY CERVICAL SPINE 4 OR 5 VIEWS	72050
<input type="checkbox"/>	XRAY CERVICAL SPINE COMPLETE W FLEX/EXT VWS	72052
<input type="checkbox"/>	XRAY CHEST 1 VIEW	71010
<input type="checkbox"/>	XRAY CHEST 2 VIEWS	71020
<input type="checkbox"/>	XRAY CLAVICLE LEFT 2 VIEWS	73000
<input type="checkbox"/>	XRAY CLAVICLE RIGHT 2 VIEWS	73000
<input type="checkbox"/>	XRAY ELBOW LEFT 2 VIEWS	73070
<input type="checkbox"/>	XRAY ELBOW LEFT MINIMUM 3 VIEWS	73080
<input type="checkbox"/>	XRAY ELBOW RIGHT 2 VIEWS	73070
<input type="checkbox"/>	XRAY ELBOW RIGHT MINIMUM 3 VIEWS	73080
<input type="checkbox"/>	XRAY EYE (FOREIGN BODY)	70030
<input type="checkbox"/>	XRAY FACIAL BONES LESS THAN 3 VIEWS	70140
<input type="checkbox"/>	XRAY FACIAL BONES MINIMUM 3 VIEWS	70150
<input type="checkbox"/>	XRAY FEMUR LEFT MINIMUM 2 VIEWS	73552
<input type="checkbox"/>	XRAY FEMUR RIGHT MINIMUM 2 VIEWS	73552
<input type="checkbox"/>	XRAY FINGER(S) LEFT MINIMUM 2 VIEWS	73140
<input type="checkbox"/>	XRAY FINGER(S) RIGHT MINIMUM 2 VIEWS	73140

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	XRAY FOOT LEFT 2 VIEWS	73620
<input type="checkbox"/>	XRAY FOOT LEFT MINIMUM 3 VIEWS	73630
<input type="checkbox"/>	XRAY FOOT RIGHT 2 VIEWS	73620
<input type="checkbox"/>	XRAY FOOT RIGHT MINIMUM 3 VIEWS	73630
<input type="checkbox"/>	XRAY FOREARM LEFT 2 VIEWS	73090
<input type="checkbox"/>	XRAY FOREARM RIGHT 2 VIEWS	73090
<input type="checkbox"/>	XRAY HAND LEFT 2 VIEWS	73120
<input type="checkbox"/>	XRAY HAND LEFT MINIMUM 3 VIEWS	73130
<input type="checkbox"/>	XRAY HAND RIGHT 2 VIEWS	73120
<input type="checkbox"/>	XRAY HAND RIGHT MINIMUM 3 VIEWS	73130
<input type="checkbox"/>	XRAY HIP LEFT W PELVIS 2 OR 3 VIEWS	73502
<input type="checkbox"/>	XRAY HIP RIGHT W PELVIS 2 OR 3 VIEWS	73502
<input type="checkbox"/>	XRAY HIPS BILATERAL W PELVIS MINIMUM 5 VWS	73523
<input type="checkbox"/>	XRAY HUMERUS LEFT MINIMUM 2 VIEWS	73060
<input type="checkbox"/>	XRAY HUMERUS RIGHT MINIMUM 2 VIEWS	73060
<input type="checkbox"/>	XRAY KNEE LEFT 1 OR 2 VIEWS	73580
<input type="checkbox"/>	XRAY KNEE LEFT 4 OR MORE VIEWS W SUNRISE	73584
<input type="checkbox"/>	XRAY KNEE LEFT 3 VIEWS	73582
<input type="checkbox"/>	XRAY KNEE RIGHT 1 OR 2 VIEWS	73580
<input type="checkbox"/>	XRAY KNEE RIGHT 4 OR MORE VIEWS W SUNRISE	73584
<input type="checkbox"/>	XRAY KNEE RIGHT 3 VIEWS	73582
<input type="checkbox"/>	XRAY KNEES BILATERAL WEIGHT BEARING	73585
<input type="checkbox"/>	XRAY LUMBAR SPINE 2 OR 3 VIEWS	72100
<input type="checkbox"/>	XRAY LUMBAR SPINE BENDING VIEWS ONLY	72120
<input type="checkbox"/>	XRAY LUMBAR SPINE COMPLETE W BENDING VWS	72114
<input type="checkbox"/>	XRAY LUMBAR SPINE MINIMUM 4 VIEWS	72110
<input type="checkbox"/>	XRAY MANDIBLE MINIMUM 4 VIEWS	70110
<input type="checkbox"/>	XRAY NASAL BONES MINIMUM 3 VIEWS	70160
<input type="checkbox"/>	XRAY ORBITS MINIMUM 4 VIEWS	70200
<input type="checkbox"/>	XRAY PELVIS 1 OR 2 VIEWS	72170

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	XRAY PELVIS MINIMUM 3 VIEWS	72190
<input type="checkbox"/>	XRAY RIBS BILATERAL 4 VIEWS W PA CHEST	71111
<input type="checkbox"/>	XRAY RIBS LEFT COMPLETE W PA CHEST	71101
<input type="checkbox"/>	XRAY RIBS RIGHT COMPLETE W PA CHEST	71101
<input type="checkbox"/>	XRAY SACROILAC JOINTS 3 OR MORE VIEWS	72202
<input type="checkbox"/>	XRAY SACRUM & COCCYX MINIMUM 2 VIEWS	72220
<input type="checkbox"/>	XRAY SCAPULA LEFT 2 VIEWS	73010
<input type="checkbox"/>	XRAY SCAPULA RIGHT 2 VIEWS	73010
<input type="checkbox"/>	XRAY SCOLIOSIS SERIES 4 OR 6 VIEWS	72063
<input type="checkbox"/>	XRAY SHOULDER LEFT MINIMUM 2 VIEWS	73030
<input type="checkbox"/>	XRAY SHOULDER RIGHT MINIMUM 2 VIEWS	73030
<input type="checkbox"/>	XRAY SINUSES MINIMUM 3 VIEWS	70220
<input type="checkbox"/>	XRAY SKULL MINIMUM 4 VIEWS	70260
<input type="checkbox"/>	XRAY SOFT TISSUE NECK 2 VIEWS	70380
<input type="checkbox"/>	XRAY STERNOCLAVICULAR JOINTS MIN. 3 VIEWS	71130
<input type="checkbox"/>	XRAY STERNUM MINIMUM 2 VIEWS	71120
<input type="checkbox"/>	XRAY TMJ BILATERAL COMPLETE	70330
<input type="checkbox"/>	XRAY THORACIC SPINE 3 VIEWS	72072
<input type="checkbox"/>	XRAY TIBIA FIBULA LEFT 2 VIEWS	73590
<input type="checkbox"/>	XRAY TIBIA FIBULA RIGHT 2 VIEWS	73590
<input type="checkbox"/>	XRAY TOE(S) LEFT MINIMUM 2 VIEWS	73660
<input type="checkbox"/>	XRAY TOE(S) RIGHT MINIMUM 2 VIEWS	73660
<input type="checkbox"/>	XRAY WRIST LEFT 2 VIEWS	73100
<input type="checkbox"/>	XRAY WRIST LEFT COMPLETE W SCAPHOID	73110
<input type="checkbox"/>	XRAY WRIST LEFT MINIMUM 3 VIEWS	73110
<input type="checkbox"/>	XRAY WRIST RIGHT 2 VIEWS	73100
<input type="checkbox"/>	XRAY WRIST RIGHT COMPLETE W SCAPHOID	73110
<input type="checkbox"/>	XRAY WRIST RIGHT MINIMUM 3 VIEWS	73110
OTHER EXAMS REQUESTED		
<input type="checkbox"/>		

Fax this order to: (928) 532-1411 Scheduling Phone: (928) 537-6564 Radiology Dept Phone: (928) 537-6338

Acct# MR#
 Adm: DOB:
 Summit Healthcare Regional Medical Center



561 (11/16)

X-RAY ORDER FORM



PO