# REQUEST FOR PORTABLE DIAGNOSTIC

| PATIENT LAST NAME | PATIENT FIRST NAME | PATIENT DATE OF BIRTH | SEX | AGE |
|---|---|---|---|---|
| | | | | |

| PATIENT STREET ADDRESS | CITY | STATE | ZIP CODE | PATIENT PHONE NUMBER |
|---|---|---|---|---|
| | | | | |

| FAX RESULTS TO | FACILITY | ROOM | MEDICARE NO. | SUFFIX | MEDICAID NO. |
|---|---|---|---|---|---|
| | | | | | |

| BILL OTHER (SPECIFY: PPO . HMO. PIP)<br>HMO'S MUST HAVE PRIOR AUTHORIZATION BEFORE SERVICE IS RENDERED | PRE-AUTHORIZATION # | POLICY # |
|---|---|---|
| | | |

| REFERRING CLINICIAN NAME | PHONE | NPI |
|---|---|---|
| | | |

| ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

## ULTRASOUND

- ☐ 76641 Breast Complete
- ☐ 76642 Breast Limited
- ☐ 76977 Bone Density
- ☐ 76881 Non-Vascular Complete
- ☐ 76882 Non-Vascular Limited
- ☐ 76700 Complete Abdominal Sonogram
- ☐ 76856 Complete Female Pelvic
- ☐ 76770 Complete Retroperitoneal
- ☐ 76775 Kidney☐ Aorta☐ Nodes☐
- ☐ 76857 Limited Female Pelvic
- ☐ 76705 Liver☐ Gallbladder☐ Spleen☐ Pancreas☐ Urinary Bladder☐
- ☐ 76870 Testicles
- ☐ 76536 Thyroid
- ☐ 76830 Transvaginal

## VASCULAR

- ☐ 93922 Ankle/Brachial Indices
- ☐ 93978 Aorta Duplex Scan
- ☐ 93979 Aorta Duplex Scan Unilateral or Limited Study
- ☐ 93925 Arterial Duplex Scan Lower Extremities
- ☐ 93926 Arterial Duplex Scan Lower Ext. Unilateral or Limited Study
- ☐ 93930 Arterial Duplex Scan Upper Extremities
- ☐ 93931 Arterial Duplex Scan Upper Ext. Unilateral or Limited Study
- ☐ 9397S Arterial Inflow & Venous Outflow
- ☐ ( Abdominal, Pelvic, Scrotal and/or Retroperitoneal Organs )
- ☐ 93976 Arterial Inflow & Venous Outflow Follow-up or Limited Study
- ☐ 93880 Carotid
- ☐ 93882 Carotid Follow-up or Limited Study
- ☐ 93923 Segmental Pressure (PVR)
- ☐ 93970 Venous Duplex Scan Bilateral
- ☐ 93971 Venous Duplex Scan Unilateral or Limited

## CARDIOVASCULAR

- ☐ 93321 Cardio Doppler Follow-up or Limited Study
- ☐ 93306 Echocardiogram Complete
- ☐ 93307 Echocardiogram M-Mode
- ☐ 93308 Echocardiogram M-Mode Follow-up or Limited Study

## CARDIAC STUDIES

- ☐ 93000 Electrocardiogram w/Interpretation & Report
- ☐ 93224 Holter Monitor 24-Hours

## RADIOLOGY

- ☐ 74000 Abdomen 1V (KUB)
- ☐ 74020 Abdomen Complete
- ☐ 73050 Acromioclavicular Joint
- ☐ 73600 Ankle 2V RT☐ LT☐
- ☐ 73610 Ankle Complete RT☐ LT☐
- ☐ 73650 Calcaneus 2V RT☐ LT☐
- ☐ 71010 Chest 1V
- ☐ 71020 Chest 2V
- ☐ 71030 Chest 4V
- ☐ 71021 Chest Apical lordotic
- ☐ 73000 Clavicle RT☐ LT☐
- ☐ 73070 Elbow 2V RT☐ LT☐
- ☐ 73080 Elbow Complete RT☐ LT☐
- ☐ 70140 Facial Bones < 3
- ☐ 70150 Facial Bones 3V
- ☐ 73552 Femur 2V RT☐ LT☐
- ☐ 73140 Finger (s) 2V RT☐ LT☐
- ☐ 73620 Foot 2V RT☐ LT☐
- ☐ 73630 Foot Complete RT☐ LT☐
- ☐ 73090 Forearm AP-LAT RT☐ LT☐
- ☐ 73170 Hand 2V RT☐ LT☐
- ☐ 73130 Hand Complete RT☐ LT☐
- ☐ 73501 Hip Unilateral-1V RT☐ LT☐
- ☐ 73502 Hip 2V
- ☐ 73521 Hip Bilateral
- ☐ 73060 Humerus RT☐ LT☐
- ☐ 73560 Knee 2V RT☐ LT☐
- ☐ 73562 Knee 3V RT☐ LT☐
- ☐ 73564 Knee Complete RT☐ LT☐
- ☐ 73565 Knee Both Standing 1V RT☐ LT☐
- ☐ 70100 Mandible < 4V
- ☐ 70110 Mandible 4V
- ☐ 70160 Nasal Bones 3V
- ☐ 70360 Neck Soft Tissue
- ☐ 70200 Orbit 4V
- ☐ 76061 Osseous Survey
- ☐ 72170 Pelvis Anti-Post
- ☐ 71100 Ribs Unilateral 2V RT☐ LT☐
- ☐ 71101 Ribs Unilateral 3V RT☐ LT☐
- ☐ 71110 Ribs Bilateral 3V
- ☐ 71111 Ribs Bilateral 4V
- ☐ 72200 Sacroiliac Joints < 3V
- ☐ 72220 Sacrum & Coccyx 2V
- ☐ 73010 Scapula
- ☐ 70240 Sella Turcica RT☐ LT☐
- ☐ 73020 Shoulder 1V RT☐ LT☐
- ☐ 73030 Shoulder Complete RT☐ LT☐
- ☐ 70220 Sinuses Paranasal 3V
- ☐ 70250 Skull <4V
- ☐ 70260 Skull 4V
- ☐ 72040 Spine Cervical AP-LAT
- ☐ 72050 Spine Cervical AP-LAT-OBL
- ☐ 72052 Spine Cervical Complete
- ☐ 77100 Spine Lumbar AP-LAT
- ☐ 72110 Spine Lumbar AP-LAT-OBL
- ☐ 72069 Spine Standing
- ☐ 72070 Spine Thoracic AP-LAT
- ☐ 72074 Spine Thoracic Complete
- ☐ 71120 Sternum 2V
- ☐ 73590 Tibia-Fibula AP-LAT RT☐ LT☐
- ☐ 70328 TMJ Unilateral RT☐ LT☐
- ☐ 70330 TMJ Bilateral
- ☐ 73660 Toe (s) RT☐ LT☐
- ☐ 73100 Wrist 2V RT☐ LT☐
- ☐ 73110 Wrist Complete RT☐ LT☐
- ☐ X-Ray Copy Needed CD

☐ **STAT**

DIAGNOSIS ( SIGNS / SYMPTOMS )

**CONDITION TO WARRANT PORTABLE X-RAY SERVICE:** ☐ Paralyzed from a stroke ☐ Severe Dementia ☐ Alzheimer's ☐ Post-Surgical Recovery ☐ Bedbound ☐ Weak and in pain
☐ Possible Non-Healing Fracture ☐ Psychiatric Illness,refusing to leave facility / home ☐ Using supporting device: _____
☐ Unable to leave Facility / home safely for x-ray ☐ Leaving facility home requires a considerable and taxing effort ☐ Other: _____

**Statement concerning the condition of the patient to warrant portable X-ray service:** The exam(s) that I ordered for this patient were medically indicated and necessary for the treatment and/or diagnosis. The patient would find it physically and/or psychologically taxing to receive **Portable X-ray service** in a place other than the exam site due to the reason(s) documented on this form. Furthermore, it would be detrimental to the patient's physical and/or mental condition to be transported for this procedure. I understand that this information may be used by (CMS) to scout the determination of medical necessity of portable X-ray services and that I have personal knowledge of the patient's condition at the time of service. **CFR 410.32 (a)**: Test must be ordered by the physician who is treating the beneficiary and will use the results in the management of the beneficiary's specific medical problem.

**PHYSICIAN SIGNATURE** _____ **PA / ARNP SIGNATURE** _____ **DATE** _____