

CT ORDER FORM

LAST NAME		TODAYS DATE	*** ICD-10 INFO REQUIRED ***	
FIRST NAME		DATE OF BIRTH	NARRATIVE SYMPTOM OR DIAGNOSIS	ICD-10 Code
PHONE	ALT. PHONE	1		
INSURANCE COMPANY		2		
POLICY #	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"/>	CT ABDOMEN & PELVIS W DYE	74177
<input type="checkbox"/>	CT ABDOMEN & PELVIS W DYE (ENTEROGRAPHY)	74177
<input type="checkbox"/>	CT ABDOMEN & PELVIS W/O & W DYE	74178
<input type="checkbox"/>	CT ABDOMEN & PELVIS W/O & W DYE (UROGRAM)	74178
<input type="checkbox"/>	CT ABDOMEN & PELVIS W/O DYE	74178
<input type="checkbox"/>	CT ABDOMEN W DYE	74180
<input type="checkbox"/>	CT ABDOMEN W/O & W DYE	74170
<input type="checkbox"/>	CT ABDOMEN W/O & W DYE (KIDNEY PROTOCOL)	74170
<input type="checkbox"/>	CT ABDOMEN W DYE (LIVER PROTOCOL)	74180
<input type="checkbox"/>	CT ABDOMEN W DYE (PANCREAS PROTOCOL)	74180
<input type="checkbox"/>	CT ABDOMEN W/O DYE	74150
<input type="checkbox"/>	CT BONE LENGTH STUDIES (SCANOGRAM)	77073
<input type="checkbox"/>	CT CERVICAL SPINE W DYE	72128
<input type="checkbox"/>	CT CERVICAL SPINE W/O & W DYE	72127
<input type="checkbox"/>	CT CERVICAL SPINE W/O DYE	72125
<input type="checkbox"/>	CT CHEST W DYE	71280
<input type="checkbox"/>	CT CHEST W/O & W DYE	71270
<input type="checkbox"/>	CT CHEST W/O DYE	71250
<input type="checkbox"/>	CT HEAD W DYE	70480
<input type="checkbox"/>	CT HEAD W/O & W DYE	70470
<input type="checkbox"/>	CT HEAD W/O DYE	70460
<input type="checkbox"/>	CT HEART W/O DYE (CORONARY CALCIUM SCORE)	75571
CT LOW DOSE SCAN FOR LUNG CANCER SCREEN *** Required information below ***		
No of pack years smoked? _____		
<input type="checkbox"/>	Patient is asymptomatic? _____	G0287
Current Smoker? _____		
Or # of years since smoking? _____		
NPI of ordering provider? _____		

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	CT LOWER EXTREMITY LEFT W DYE	73701
<input type="checkbox"/>	CT LOWER EXTREMITY LEFT W/O & W DYE	73702
<input type="checkbox"/>	CT LOWER EXTREMITY LEFT W/O DYE	73700
<input type="checkbox"/>	CT LOWER EXTREMITY RIGHT W DYE	73701
<input type="checkbox"/>	CT LOWER EXTREMITY RIGHT W/O & W DYE	73702
<input type="checkbox"/>	CT LOWER EXTREMITY RIGHT W/O DYE	73700
<input type="checkbox"/>	CT LUMBAR SPINE W DYE	72132
<input type="checkbox"/>	CT LUMBAR SPINE W/O & W DYE	72133
<input type="checkbox"/>	CT LUMBAR SPINE W/O DYE	72131
<input type="checkbox"/>	CT MAXILLOFACIAL W DYE	70487
<input type="checkbox"/>	CT MAXILLOFACIAL W/O & W DYE	70488
<input type="checkbox"/>	CT MAXILLOFACIAL W/O DYE	70486
<input type="checkbox"/>	CT ORBITS W DYE	70481
<input type="checkbox"/>	CT ORBITS W/O & W DYE	70482
<input type="checkbox"/>	CT ORBITS W/O DYE	70480
<input type="checkbox"/>	CT PELVIS W DYE	72183
<input type="checkbox"/>	CT PELVIS W/O & W DYE	72184
<input type="checkbox"/>	CT PELVIS W/O DYE	72182
<input type="checkbox"/>	CT SINUSES W DYE	70487
<input type="checkbox"/>	CT SINUSES W/O & W DYE	70488
<input type="checkbox"/>	CT SINUSES W/O DYE	70486
<input type="checkbox"/>	CT SOFT TISSUE NECK W DYE	70481
<input type="checkbox"/>	CT SOFT TISSUE NECK W/O & W DYE	70482
<input type="checkbox"/>	CT SOFT TISSUE NECK W/O DYE	70480
<input type="checkbox"/>	CT TEMPORAL BONE W DYE	70481
<input type="checkbox"/>	CT TEMPORAL BONE W/O & W DYE	70482
<input type="checkbox"/>	CT TEMPORAL BONE W/O DYE	70480
<input type="checkbox"/>	CT THORACIC SPINE W DYE	72129

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	CT THORACIC SPINE W/O & W DYE	72130
<input type="checkbox"/>	CT THORACIC SPINE W/O DYE	72128
<input type="checkbox"/>	CT UPPER EXTREMITY LEFT W DYE	73201
<input type="checkbox"/>	CT UPPER EXTREMITY LEFT W/O & W DYE	73202
<input type="checkbox"/>	CT UPPER EXTREMITY LEFT W/O DYE	73200
<input type="checkbox"/>	CT UPPER EXTREMITY RIGHT W DYE	73201
<input type="checkbox"/>	CT UPPER EXTREMITY RIGHT W/O & W DYE	73202
<input type="checkbox"/>	CT UPPER EXTREMITY RIGHT W/O DYE	73200
CT Angiography		
<input type="checkbox"/>	CTA ABDOMEN & PELVIS W DYE	74174
<input type="checkbox"/>	CTA ABDOMEN W DYE	74175
<input type="checkbox"/>	CTA ABDOMINAL AORTA & LE RUNOFF W DYE	78635
<input type="checkbox"/>	CTA CHEST W DYE (PE PROTOCOL)	71275
<input type="checkbox"/>	CTA CHEST W DYE (THORACIC AORTA PROTOCOL)	71275
<input type="checkbox"/>	CTA CHEST/ABDOMEN W DYE (COMPLETE AORTA PROTOCOL)	71275 74175
<input type="checkbox"/>	CTA HEAD W DYE	70489
<input type="checkbox"/>	CTA HEART & CORONARY ARTERIES W DYE	78574
<input type="checkbox"/>	CTA LOWER EXTREMITY LEFT W DYE	73708
<input type="checkbox"/>	CTA LOWER EXTREMITY RIGHT W DYE	73708
<input type="checkbox"/>	CTA NECK W DYE	70489
<input type="checkbox"/>	CTA UPPER EXTREMITY LEFT W DYE	73208
<input type="checkbox"/>	CTA UPPER EXTREMITY RIGHT W DYE	73208
OTHER EXAMS REQUESTED		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

Fax this order to: (928) 532-1411 Scheduling Phone: (928) 537-6554 Radiology Dept Phone: (928) 537-6338



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

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