

# X-RAY ORDER FORM

LAST NAME		TODAYS DATE	<b>*** ICD-10 INFO REQUIRED ***</b>	
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  <input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT (Need results w/in 24 hrs) <input type="checkbox"/> STAT (Need results immediately)		
PHYSICIAN TELEPHONE NUMBER				
PHYSICIAN SIGNATURE <b>*** (REQUIRED)</b>		PRE-AUTH REQUIRED: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> PRE-AUTH #		

<input checked="" type="checkbox"/>	EXAM	CPT	<input checked="" type="checkbox"/>	EXAM	CPT	<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	XRAY ABDOMEN ACUTE SERIES	74022	<input type="checkbox"/>	XRAY FOOT LEFT 2 VIEWS	73620	<input type="checkbox"/>	XRAY PELVIS MINIMUM 3 VIEWS	72190
<input type="checkbox"/>	XRAY ABDOMEN 1 VIEW	74018	<input type="checkbox"/>	XRAY FOOT LEFT MINIMUM 3 VIEWS	73630	<input type="checkbox"/>	XRAY RIBS BILATERAL 4 VIEWS W PA CHEST	71111
<input type="checkbox"/>	XRAY ABDOMEN 2 VIEWS	74019	<input type="checkbox"/>	XRAY FOOT RIGHT 2 VIEWS	73620	<input type="checkbox"/>	XRAY RIBS LEFT COMPLETE W PA CHEST	71101
<input type="checkbox"/>	XRAY AC JOINTS BILATERAL W/O OR W WEIGHTS	73050	<input type="checkbox"/>	XRAY FOOT RIGHT MINIMUM 3 VIEWS	73630	<input type="checkbox"/>	XRAY RIBS RIGHT COMPLETE W PA CHEST	71101
<input type="checkbox"/>	XRAY ANKLE LEFT 2 VIEWS	73600	<input type="checkbox"/>	XRAY FOREARM LEFT 2 VIEWS	73090	<input type="checkbox"/>	XRAY SACROILIAC JOINTS 3 OR MORE VIEWS	72202
<input type="checkbox"/>	XRAY ANKLE LEFT MINIMUM 3 VIEWS	73610	<input type="checkbox"/>	XRAY FOREARM RIGHT 2 VIEWS	73090	<input type="checkbox"/>	XRAY SACRUM & COCCYX MINIMUM 2 VIEWS	72220
<input type="checkbox"/>	XRAY ANKLE RIGHT 2 VIEWS	73600	<input type="checkbox"/>	XRAY HAND LEFT 2 VIEWS	73120	<input type="checkbox"/>	XRAY SCAPULA LEFT 2 VIEWS	73010
<input type="checkbox"/>	XRAY ANKLE RIGHT MINIMUM 3 VIEWS	73610	<input type="checkbox"/>	XRAY HAND LEFT MINIMUM 3 VIEWS	73130	<input type="checkbox"/>	XRAY SCAPULA RIGHT 2 VIEWS	73010
<input type="checkbox"/>	XRAY BONE AGE STUDY	77072	<input type="checkbox"/>	XRAY HAND RIGHT 2 VIEWS	73120	<input type="checkbox"/>	XRAY SCOLIOSIS SERIES 4 OR 5 VIEWS	72083
<input type="checkbox"/>	XRAY BONE LENGTH STUDY	77073	<input type="checkbox"/>	XRAY HAND RIGHT MINIMUM 3 VIEWS	73130	<input type="checkbox"/>	XRAY SHOULDER LEFT MINIMUM 2 VIEWS	73030
<input type="checkbox"/>	XRAY CALCANEUS LEFT MINIMUM 2 VIEWS	73650	<input type="checkbox"/>	XRAY HIP LEFT W PELVIS 2 OR 3 VIEWS	73502	<input type="checkbox"/>	XRAY SHOULDER RIGHT MINIMUM 2 VIEWS	73030
<input type="checkbox"/>	XRAY CALCANEUS RIGHT MINIMUM 2 VIEWS	73650	<input type="checkbox"/>	XRAY HIP RIGHT W PELVIS 2 OR 3 VIEWS	73502	<input type="checkbox"/>	XRAY SINUSES MINIMUM 3 VIEWS	70220
<input type="checkbox"/>	XRAY CERVICAL SPINE 2 OR 3 VIEWS	72040	<input type="checkbox"/>	XRAY HIPS BILATERAL W PELVIS MINIMUM 5 VWS	73523	<input type="checkbox"/>	XRAY SKULL MINIMUM 4 VIEWS	70260
<input type="checkbox"/>	XRAY CERVICAL SPINE 4 OR 5 VIEWS	72050	<input type="checkbox"/>	XRAY HUMERUS LEFT MINIMUM 2 VIEWS	73060	<input type="checkbox"/>	XRAY SOFT TISSUE NECK 2 VIEWS	70360
<input type="checkbox"/>	XRAY CERVICAL SPINE COMPLETE W FLEX/EXT VWS	72052	<input type="checkbox"/>	XRAY HUMERUS RIGHT MINIMUM 2 VIEWS	73060	<input type="checkbox"/>	XRAY STERNOCLAVICULAR JOINTS MIN. 3 VIEWS	71130
<input type="checkbox"/>	XRAY CHEST 1 VIEW	71045	<input type="checkbox"/>	XRAY KNEE LEFT 1 OR 2 VIEWS	73560	<input type="checkbox"/>	XRAY STERNUM MINIMUM 2 VIEWS	71120
<input type="checkbox"/>	XRAY CHEST 2 VIEWS	71046	<input type="checkbox"/>	XRAY KNEE LEFT 4 OR MORE VIEWS W SUNRISE	73564	<input type="checkbox"/>	XRAY TMJ BILATERAL COMPLETE	70330
<input type="checkbox"/>	XRAY CLAVICLE LEFT 2 VIEWS	73000	<input type="checkbox"/>	XRAY KNEE LEFT 3 VIEWS	73562	<input type="checkbox"/>	XRAY THORACIC SPINE 3 VIEWS	72072
<input type="checkbox"/>	XRAY CLAVICLE RIGHT 2 VIEWS	73000	<input type="checkbox"/>	XRAY KNEE RIGHT 1 OR 2 VIEWS	73560	<input type="checkbox"/>	XRAY TIBIA FIBULA LEFT 2 VIEWS	73590
<input type="checkbox"/>	XRAY ELBOW LEFT 2 VIEWS	73070	<input type="checkbox"/>	XRAY KNEE RIGHT 4 OR MORE VIEWS W SUNRISE	73564	<input type="checkbox"/>	XRAY TIBIA FIBULA RIGHT 2 VIEWS	73590
<input type="checkbox"/>	XRAY ELBOW LEFT MINIMUM 3 VIEWS	73080	<input type="checkbox"/>	XRAY KNEE RIGHT 3 VIEWS	73562	<input type="checkbox"/>	XRAY TOE(S) LEFT MINIMUM 2 VIEWS	73660
<input type="checkbox"/>	XRAY ELBOW RIGHT 2 VIEWS	73070	<input type="checkbox"/>	XRAY KNEES BILATERAL WEIGHT BEARING	73565	<input type="checkbox"/>	XRAY TOE(S) RIGHT MINIMUM 2 VIEWS	73660
<input type="checkbox"/>	XRAY ELBOW RIGHT MINIMUM 3 VIEWS	73080	<input type="checkbox"/>	XRAY LUMBAR SPINE 2 OR 3 VIEWS	72100	<input type="checkbox"/>	XRAY WRIST LEFT 2 VIEWS	73100
<input type="checkbox"/>	XRAY EYE (FOREIGN BODY)	70030	<input type="checkbox"/>	XRAY LUMBAR SPINE BENDING VIEWS ONLY	72120	<input type="checkbox"/>	XRAY WRIST LEFT COMPLETE W SCAPHOID	73110
<input type="checkbox"/>	XRAY FACIAL BONES LESS THAN 3 VIEWS	70140	<input type="checkbox"/>	XRAY LUMBAR SPINE COMPLETE W BENDING VWS	72114	<input type="checkbox"/>	XRAY WRIST LEFT MINIMUM 3 VIEWS	73110
<input type="checkbox"/>	XRAY FACIAL BONES MINIMUM 3 VIEWS	70150	<input type="checkbox"/>	XRAY LUMBAR SPINE MINIMUM 4 VIEWS	72110	<input type="checkbox"/>	XRAY WRIST RIGHT 2 VIEWS	73100
<input type="checkbox"/>	XRAY FEMUR LEFT MINIMUM 2 VIEWS	73552	<input type="checkbox"/>	XRAY MANDIBLE MINIMUM 4 VIEWS	70110	<input type="checkbox"/>	XRAY WRIST RIGHT COMPLETE W SCAPHOID	73110
<input type="checkbox"/>	XRAY FEMUR RIGHT MINIMUM 2 VIEWS	73552	<input type="checkbox"/>	XRAY NASAL BONES MINIMUM 3 VIEWS	70160	<input type="checkbox"/>	XRAY WRIST RIGHT MINIMUM 3 VIEWS	73110
<input type="checkbox"/>	XRAY FINGER(S) LEFT MINIMUM 2 VIEWS	73140	<input type="checkbox"/>	XRAY ORBITS MINIMUM 4 VIEWS	70200	<b>OTHER EXAMS REQUESTED</b>		
<input type="checkbox"/>	XRAY FINGER(S) RIGHT MINIMUM 2 VIEWS	73140	<input type="checkbox"/>	XRAY PELVIS 1 OR 2 VIEWS	72170	<input type="checkbox"/>		

Fax this order to: (928) 532-1411

Scheduling Phone: (928) 537-6554

Radiology Dept Phone: (928) 537-6338



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