

ULTRASOUND 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					
POLICY #		GROUP #			
PHYSICIAN NAME		SPECIAL INSTRUCTIONS <input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT			
OFFICE TELEPHONE NUMBER					
PHYSICIAN SIGNATURE *** (REQUIRED)		PRE-AUTH REQUIRED: Y <input type="checkbox"/> N <input type="checkbox"/> PRE-AUTH #			

<input checked="" type="checkbox"/>	EXAM	CPT
ULTRASOUND		
<input type="checkbox"/>	US ABDOMEN COMPLETE	76700
<input type="checkbox"/>	US ABDOMEN LIMITED	76705
<input type="checkbox"/>	US ABDOMINAL AORTA FOR ANEURYSM SCREEN	76775
<input type="checkbox"/>	US AMNIOCENTESIS	76948
<input type="checkbox"/>	US ANKLE BRACHIAL INDEX (1-2 LEVELS)	93922
<input type="checkbox"/>	US ANKLE BRACHIAL INDEX (3 OR MORE LEVELS)	93923
<input type="checkbox"/>	US BREAST UNILATERAL COMPLETE	76641
<input type="checkbox"/>	US BREAST UNILATERAL LIMITED	76642
<input type="checkbox"/>	US CHEST	76804
<input type="checkbox"/>	US CHEST FOR PERICARDIAL EFFUSION	76804
<input type="checkbox"/>	US COMPRESSION REPAIR OF PSEUDOANEURYSM	76936
<input type="checkbox"/>	US DUPLEX AORTA, IVC, & ILIAC VASCULATURE	93978
<input type="checkbox"/>	US DUPLEX CAROTID ARTERIES COMPLETE	93880
<input type="checkbox"/>	US DUPLEX GROIN FOR PSEUDOANEURYSM	93926
<input type="checkbox"/>	US DUPLEX HEMODIALYSIS ACCESS	93990
<input type="checkbox"/>	US DUPLEX KIDNEYS (ARTERIAL & VENOUS)	93975 76770
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES BILAT	93925
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES LEFT	93926
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES RIGHT	93926
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS BILATERAL	93970
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS LEFT	93971
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS RIGHT	93971
<input type="checkbox"/>	US DUPLEX LE VENOUS INSUFFICIENCY BILATERAL	93970
<input type="checkbox"/>	US DUPLEX LE VENOUS INSUFFICIENCY LEFT	93971

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	US DUPLEX LE VENOUS INSUFFICIENCY RIGHT	93971
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES BILAT	93930
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES LEFT	93931
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES RIGHT	93931
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS BILATERAL	93970
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS LEFT	93971
<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS RIGHT	93971
<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSESOPHAGEAL (TEE)	93312
<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC COMPL	93308
<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC W DYE	C8929
<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC W REST & STRESS	93350
<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC LIMITED	93308
<input type="checkbox"/>	US EXTREMITY SOFT TISSUES (NONVASCULAR)	76882
<input type="checkbox"/>	US FETAL BPP W NON-STRESS TESTING	76818
<input type="checkbox"/>	US FETAL BPP W/O NON-STRESS TESTING	76819
<input type="checkbox"/>	US GALLBLADDER	76705
<input type="checkbox"/>	US HEAD/BRAIN NEONATAL	76506
<input type="checkbox"/>	US INFANT HIPS DYNAMIC REQUIRING PHYSICIAN	76885
<input type="checkbox"/>	US LIVER	76705
<input type="checkbox"/>	US OB COMPLETE < 14 WKS TRANSABDOMINAL/VAGINAL	76801 76817
<input type="checkbox"/>	US OB COMPL < 14 WKS TRANSABDOMINAL	76801
<input type="checkbox"/>	US OB COMPLETE > 14 WKS TRANSABDOMINAL	76805
<input type="checkbox"/>	US OB FOLLOW-UP TRANSABDOMINAL	76816
<input type="checkbox"/>	US OB LIMITED TRANSABDOMINAL	76815

<input checked="" type="checkbox"/>	EXAM	CPT
<input type="checkbox"/>	US OB TRANSVAGINAL	76817
<input type="checkbox"/>	US PELVIS COMPLETE TRANSABDOMINAL/VAGINAL (NONOB)	76856 76830
<input type="checkbox"/>	US PELVIS COMPLETE TRANSABDOMINAL (NONOB)	76856
<input type="checkbox"/>	US PELVIS LIMITED TRANSABDOMINAL (NONOB)	76857
<input type="checkbox"/>	US RETROPERITONEAL COMPL (KIDNEYS/BLADDER)	76770
<input type="checkbox"/>	US SCROTUM & CONTENTS	76870
<input type="checkbox"/>	US SOFT TISSUES OF HEAD & NECK	76536
<input type="checkbox"/>	US SONOHYSTEROGRAM BY SALINE INFUSION	76831 58340
<input type="checkbox"/>	US SPINAL CANAL & CONTENTS	76800
<input type="checkbox"/>	US THYROID	76536
<input type="checkbox"/>	US TRANSPLANT KIDNEY W DOPPLER	76776
<input type="checkbox"/>	US URINARY BLADDER	76775
OTHER EXAMS REQUESTED		
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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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