X-RAY 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		☐ ROUTINE ☐ URGENT	
PHYSICIAN SIGNATURE *** (REQUIRED)		PRE-AUTH REQUIRED: Y ☐ N ☐ PRE-AUTH #	

☑	EXAM	CPT
☐	XRAY ABDOMEN ACUTE SERIES	74022
☐	XRAY ABDOMEN 1 VIEW	74000
☐	XRAY ABDOMEN SUPINE & ERECT VIEWS	74020
☐	XRAY AC JOINTS BILATERAL W/O OR W WEIGHTS	73050
☐	XRAY ANKLE LEFT 2 VIEWS	73600
☐	XRAY ANKLE LEFT MINIMUM 3 VIEWS	73610
☐	XRAY ANKLE RIGHT 2 VIEWS	73600
☐	XRAY ANKLE RIGHT MINIMUM 3 VIEWS	73610
☐	XRAY BONE AGE STUDY	77072
☐	XRAY BONE LENGTH STUDY	77073
☐	XRAY CALCANEUS LEFT MINIMUM 2 VIEWS	73650
☐	XRAY CALCANEUS RIGHT MINIMUM 2 VIEWS	73650
☐	XRAY CERVICAL SPINE 2 OR 3 VIEWS	72040
☐	XRAY CERVICAL SPINE 4 OR 5 VIEWS	72050
☐	XRAY CERVICAL SPINE COMPLETE W FLEX/EXT VWS	72052
☐	XRAY CHEST 1 VIEW	71010
☐	XRAY CHEST 2 VIEWS	71020
☐	XRAY CLAVICLE LEFT 2 VIEWS	73000
☐	XRAY CLAVICLE RIGHT 2 VIEWS	73000
☐	XRAY ELBOW LEFT 2 VIEWS	73070
☐	XRAY ELBOW LEFT MINIMUM 3 VIEWS	73080
☐	XRAY ELBOW RIGHT 2 VIEWS	73070
☐	XRAY ELBOW RIGHT MINIMUM 3 VIEWS	73080
☐	XRAY EYE (FOREIGN BODY)	70030
☐	XRAY FACIAL BONES LESS THAN 3 VIEWS	70140
☐	XRAY FACIAL BONES MINIMUM 3 VIEWS	70150
☐	XRAY FEMUR LEFT MINIMUM 2 VIEWS	73552
☐	XRAY FEMUR RIGHT MINIMUM 2 VIEWS	73552
☐	XRAY FINGER(S) LEFT MINIMUM 2 VIEWS	73140
☐	XRAY FINGER(S) RIGHT MINIMUM 2 VIEWS	73140

☑	EXAM	CPT
☐	XRAY FOOT LEFT 2 VIEWS	73620
☐	XRAY FOOT LEFT MINIMUM 3 VIEWS	73630
☐	XRAY FOOT RIGHT 2 VIEWS	73620
☐	XRAY FOOT RIGHT MINIMUM 3 VIEWS	73630
☐	XRAY FOREARM LEFT 2 VIEWS	73090
☐	XRAY FOREARM RIGHT 2 VIEWS	73090
☐	XRAY HAND LEFT 2 VIEWS	73120
☐	XRAY HAND LEFT MINIMUM 3 VIEWS	73130
☐	XRAY HAND RIGHT 2 VIEWS	73120
☐	XRAY HAND RIGHT MINIMUM 3 VIEWS	73130
☐	XRAY HIP LEFT W PELVIS 2 OR 3 VIEWS	73502
☐	XRAY HIP RIGHT W PELVIS 2 OR 3 VIEWS	73502
☐	XRAY HIPS BILATERAL W PELVIS MINIMUM 5 VWS	73523
☐	XRAY HUMERUS LEFT MINIMUM 2 VIEWS	73060
☐	XRAY HUMERUS RIGHT MINIMUM 2 VIEWS	73060
☐	XRAY KNEE LEFT 1 OR 2 VIEWS	73560
☐	XRAY KNEE LEFT 4 OR MORE VIEWS W SUNRISE	73564
☐	XRAY KNEE LEFT 3 VIEWS	73562
☐	XRAY KNEE RIGHT 1 OR 2 VIEWS	73560
☐	XRAY KNEE RIGHT 4 OR MORE VIEWS W SUNRISE	73564
☐	XRAY KNEE RIGHT 3 VIEWS	73562
☐	XRAY KNEES BILATERAL WEIGHT BEARING	73565
☐	XRAY LUMBAR SPINE 2 OR 3 VIEWS	72100
☐	XRAY LUMBAR SPINE BENDING VIEWS ONLY	72120
☐	XRAY LUMBAR SPINE COMPLETE W BENDING VWS	72114
☐	XRAY LUMBAR SPINE MINIMUM 4 VIEWS	72110
☐	XRAY MANDIBLE MINIMUM 4 VIEWS	70110
☐	XRAY NASAL BONES MINIMUM 3 VIEWS	70160
☐	XRAY ORBITS MINIMUM 4 VIEWS	70200
☐	XRAY PELVIS 1 OR 2 VIEWS	72170

☑	EXAM	CPT
☐	XRAY PELVIS MINIMUM 3 VIEWS	72190
☐	XRAY RIBS BILATERAL 4 VIEWS W PA CHEST	71111
☐	XRAY RIBS LEFT COMPLETE W PA CHEST	71101
☐	XRAY RIBS RIGHT COMPLETE W PA CHEST	71101
☐	XRAY SACROILIAC JOINTS 3 OR MORE VIEWS	72202
☐	XRAY SACRUM & COCCYX MINIMUM 2 VIEWS	72220
☐	XRAY SCAPULA LEFT 2 VIEWS	73010
☐	XRAY SCAPULA RIGHT 2 VIEWS	73010
☐	XRAY SCOLIOSIS SERIES 4 OR 5 VIEWS	72083
☐	XRAY SHOULDER LEFT MINIMUM 2 VIEWS	73030
☐	XRAY SHOULDER RIGHT MINIMUM 2 VIEWS	73030
☐	XRAY SINUSES MINIMUM 3 VIEWS	70220
☐	XRAY SKULL MINIMUM 4 VIEWS	70260
☐	XRAY SOFT TISSUE NECK 2 VIEWS	70360
☐	XRAY STERNOCLAVICULAR JOINTS MIN. 3 VIEWS	71130
☐	XRAY STERNUM MINIMUM 2 VIEWS	71120
☐	XRAY TMJ BILATERAL COMPLETE	70330
☐	XRAY THORACIC SPINE 3 VIEWS	72072
☐	XRAY TIBIA FIBULA LEFT 2 VIEWS	73590
☐	XRAY TIBIA FIBULA RIGHT 2 VIEWS	73590
☐	XRAY TOE(S) LEFT MINIMUM 2 VIEWS	73660
☐	XRAY TOE(S) RIGHT MINIMUM 2 VIEWS	73660
☐	XRAY WRIST LEFT 2 VIEWS	73100
☐	XRAY WRIST LEFT COMPLETE W SCAPHOID	73110
☐	XRAY WRIST LEFT MINIMUM 3 VIEWS	73110
☐	XRAY WRIST RIGHT 2 VIEWS	73100
☐	XRAY WRIST RIGHT COMPLETE W SCAPHOID	73110
☐	XRAY WRIST RIGHT MINIMUM 3 VIEWS	73110
	OTHER EXAMS REQUESTED	
☐		

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

561 (11/16)

Acct# MR#

Adm: DOB:
Summit Healthcare Regional Medical Center

X-RAY ORDER FORM

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