

ULTRASOUND 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 checked="" type="checkbox"/>	EXAM	CPT	<input checked="" type="checkbox"/>	EXAM	CPT
	ULTRASOUND			<input type="checkbox"/> US DUPLEX LE VENOUS INSUFFICIENCY RIGHT	93971		<input type="checkbox"/> US OB TRANSVAGINAL	76817
<input type="checkbox"/>	US ABDOMEN COMPLETE	76700	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES BILAT	93930	<input type="checkbox"/>	US PELVIS COMPLETE TRANSABDOMINAL/VAGINAL (NONOB)	76856 76830
<input type="checkbox"/>	US ABDOMEN LIMITED	76705	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES LEFT	93931	<input type="checkbox"/>	US PELVIS COMPLETE TRANSABDOMINAL (NONOB)	76856
<input type="checkbox"/>	US ABDOMINAL AORTA FOR ANEURYSM SCREEN	76706	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY ARTERIES RIGHT	93931	<input type="checkbox"/>	US PELVIS LIMITED TRANSABDOMINAL (NONOB)	76857
<input type="checkbox"/>	US AMNIOCENTESIS	76946	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS BILATERAL	93970	<input type="checkbox"/>	US RETROPERITONEAL COMPL (KIDNEYS/BLADDER)	76770
<input type="checkbox"/>	US ANKLE BRACHIAL INDEX (1-2 LEVELS)	93922	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS LEFT	93971	<input type="checkbox"/>	US SCROTUM & CONTENTS	76870
<input type="checkbox"/>	US ANKLE BRACHIAL INDEX (3 OR MORE LEVELS)	93923	<input type="checkbox"/>	US DUPLEX UPPER EXTREMITY VEINS RIGHT	93971	<input type="checkbox"/>	US SOFT TISSUES OF HEAD & NECK	76536
<input type="checkbox"/>	US BREAST UNILATERAL COMPLETE	76641	<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSESOPHAGEAL (TEE)	93312	<input type="checkbox"/>	US SONOHYSTEROGRAM BY SALINE INFUSION	76831 58340
<input type="checkbox"/>	US BREAST UNILATERAL LIMITED	76642	<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC COMPL	93306	<input type="checkbox"/>	US SPINAL CANAL & CONTENTS	76800
<input type="checkbox"/>	US CHEST	76604	<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC W DYE	C8929	<input type="checkbox"/>	US THYROID	76536
<input type="checkbox"/>	US CHEST FOR PERICARDIAL EFFUSION	76604	<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC W REST & STRESS	93350	<input type="checkbox"/>	US TRANSPLANT KIDNEY W DOPPLER	76776
<input type="checkbox"/>	US COMPRESSION REPAIR OF PSEUDOANEURYSM	76936	<input type="checkbox"/>	US ECHOCARDIOGRAM TRANSTHORACIC LIMITED	93308	<input type="checkbox"/>	US URINARY BLADDER	76775
<input type="checkbox"/>	US DUPLEX AORTA, IVC, & ILIAC VASCULATURE	93978	<input type="checkbox"/>	US EXTREMITY SOFT TISSUES (NONVASCULAR)	76882	OTHER EXAMS REQUESTED		
<input type="checkbox"/>	US DUPLEX CAROTID ARTERIES COMPLETE	93880	<input type="checkbox"/>	US FETAL BPP W NON-STRESS TESTING	76818	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX GROIN FOR PSEUDOANEURYSM	93926	<input type="checkbox"/>	US FETAL BPP W/O NON-STRESS TESTING	76819	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX HEMODIALYSIS ACCESS	93990	<input type="checkbox"/>	US GALLBLADDER	76705	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX KIDNEYS (ARTERIAL & VENOUS)	93975 76770	<input type="checkbox"/>	US HEAD/BRAIN NEONATAL	76506	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES BILAT	93925	<input type="checkbox"/>	US INFANT HIPS DYNAMIC REQUIRING PHYSICIAN	76885	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES LEFT	93926	<input type="checkbox"/>	US LIVER	76705	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY ARTERIES RIGHT	93926	<input type="checkbox"/>	US OB COMPLETE <14 WKS TRANSABDOMINAL/VAGINAL	76801 76817	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS BILATERAL	93970	<input type="checkbox"/>	US OB COMPL <14 WKS TRANSABDOMINAL	76801	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS LEFT	93971	<input type="checkbox"/>	US OB COMPLETE >14 WKS TRANSABDOMINAL	76805	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LOWER EXTREMITY VEINS RIGHT	93971	<input type="checkbox"/>	US OB FOLLOW-UP TRANSABDOMINAL	76816	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LE VENOUS INSUFFICIENCY BILATERAL	93970	<input type="checkbox"/>	US OB LIMITED TRANSABDOMINAL	76815	<input type="checkbox"/>		
<input type="checkbox"/>	US DUPLEX LE VENOUS INSUFFICIENCY LEFT	93971						

Fax this order to: (928) 532-1411

Scheduling Phone: (928) 537-6554

Radiology Dept Phone: (928) 537-6338



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