

# FLUOROSCOPY 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(S)
<b>ARTHROGRAM</b>		
<input type="checkbox"/>	ARTHROGRAM ANKLE LEFT WITH MRI ANKLE LEFT POST ARTHROGRAM	73815, 27648, 73722
<input type="checkbox"/>	ARTHROGRAM ANKLE RIGHT WITH MRI ANKLE RIGHT POST ARTHROGRAM	73815, 27648, 73722
<input type="checkbox"/>	ARTHROGRAM ELBOW LEFT WITH MRI ELBOW LEFT POST ARTHROGRAM	73085, 24220, 73222
<input type="checkbox"/>	ARTHROGRAM ELBOW RIGHT WITH MRI ELBOW RIGHT POST ARTHROGRAM	73085, 24220, 73222
<input type="checkbox"/>	ARTHROGRAM HIP LEFT WITH MRI HIP LEFT POST ARTHROGRAM	73525, 27093, 73722
<input type="checkbox"/>	ARTHROGRAM HIP RIGHT WITH MRI HIP RIGHT POST ARTHROGRAM	73525, 27093, 73722
<input type="checkbox"/>	ARTHROGRAM KNEE LEFT WITH MRI KNEE LEFT POST ARTHROGRAM	73580, 27370, 73722
<input type="checkbox"/>	ARTHROGRAM KNEE RIGHT WITH MRI KNEE RIGHT POST ARTHROGRAM	73580, 27370, 73722
<input type="checkbox"/>	ARTHROGRAM KNEE LEFT WITH CT KNEE LEFT POST ARTHROGRAM	73580, 27370, 73701
<input type="checkbox"/>	ARTHROGRAM KNEE RIGHT WITH CT KNEE RIGHT POST ARTHROGRAM	73580, 27370, 73701
<input type="checkbox"/>	ARTHROGRAM SHOULDER LEFT WITH MRI SHOULDER LEFT POST ARTHROGRAM	73040, 23350, 73222
<input type="checkbox"/>	ARTHROGRAM SHOULDER RIGHT WITH MRI SHOULDER RIGHT POST ARTHROGRAM	73040, 23350, 73222
<input type="checkbox"/>	ARTHROGRAM SHOULDER LEFT WITH CT SHOULDER LEFT POST ARTHROGRAM	73040, 23350, 73201
<input type="checkbox"/>	ARTHROGRAM SHOULDER RIGHT WITH CT SHOULDER RIGHT POST ARTHROGRAM	73040, 23350, 73201
<input type="checkbox"/>	ARTHROGRAM WRIST LEFT WITH MRI WRIST LEFT POST ARTHROGRAM	73115, 25246, 73222
<input type="checkbox"/>	ARTHROGRAM WRIST RIGHT WITH MRI WRIST RIGHT POST ARTHROGRAM	73115, 25246, 73222

<input checked="" type="checkbox"/>	EXAM	CPT(S)
<b>GASTROINTESTINAL TRACT</b>		
<input type="checkbox"/>	BARIUM ENEMA DOUBLE CONTRAST	74280
<input type="checkbox"/>	BARIUM ENEMA SINGLE CONTRAST	74270
<input type="checkbox"/>	ESOPHAGRAM	74220
<input type="checkbox"/>	LAP BAND ADJUSTMENT W FLUOROSCOPY	52083, 77002
<input type="checkbox"/>	SMALL INTESTINE FOLLOW-THROUGH	74250
<input type="checkbox"/>	SWALLOWING FUNCTION (MODIFIED BARIUM)	74230
<input type="checkbox"/>	UPPER GI DOUBLE CONTRAST W KUB	74247
<input type="checkbox"/>	UPPER GI DOUBLE CONTRAST W SMALL INTESTINE FOLLOW THROUGH	74249
<input type="checkbox"/>	UPPER GI SINGLE CONTRAST W KUB	74241
<b>GYNECOLOGICAL</b>		
<input type="checkbox"/>	HYSTEROSALPINGOGRAM	74740, 58340
<b>MYELOGRAM</b>		
<input type="checkbox"/>	MYELOGRAM CERVICAL SPINE WITH CT CERVICAL SPINE POST MYELOGRAM	62302, 72126
<input type="checkbox"/>	MYELOGRAM THORACIC SPINE WITH CT THORACIC SPINE POST MYELOGRAM	62303, 72129
<input type="checkbox"/>	MYELOGRAM LUMBAR SPINE WITH CT LUMBAR SPINE POST MYELOGRAM	62304, 72132
<b>URINARY TRACT</b>		
<input type="checkbox"/>	CYSTOGRAM	74430, 51600
<input type="checkbox"/>	LOOPOGRAM THROUGH AN ILEAL CONDUIT	74425, 50680
<input type="checkbox"/>	NEPHROSTOGRAM VIA NEPHROSTOMY CATHETER	50431
<input type="checkbox"/>	URETHROCYSTOGRAPHY RETROGRADE	74450, 51610
<input type="checkbox"/>	URETHROCYSTOGRAPHY VOIDING (VCUG)	74455, 51600
<b>OTHER</b>		
<input type="checkbox"/>	CHOLANGIOGRAM THROUGH EXISTING CATHETER	47531
<input type="checkbox"/>	PORTACATH FLUSH	96523
<input type="checkbox"/>	SNIFF TEST (CXR 2 VIEWS W FLUOROSCOPY)	71023
<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



555 (11/18)

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

FLUOROSCOPY ORDER FORM



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