



2360 W 68 St. #128 • Hialeah, FL 33016

**Type of Insurance: (circle)**

PIP L.O.P. W/C Health Ins. Medicare Self-Pay

Primary Insurance Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim # \_\_\_\_\_

ID/Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Authorization #: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Special Requests:  CD needed  Transportation

Diagnosis: \_\_\_\_\_

**APPOINTMENT:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

Ref. Doctor's Name: \_\_\_\_\_

Ref. Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**STAT** Dr. Requests Call to (\_\_\_\_\_) \_\_\_\_\_  
Fax Prelim to (\_\_\_\_\_) \_\_\_\_\_

**IMPORTANT: PLEASE CHOOSE IV CONTRAST OPTION BY CIRCLING THE APPROPRIATE CPT CODE**

CT	wo IV	w IV	w & wo IV
<input type="checkbox"/> Head	70450	70460	70470
<input type="checkbox"/> Sinuses: Complete	70486	70487	70488
<input type="checkbox"/> IAC <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Mastoids	70480	70481	70482
<input type="checkbox"/> Max/Facial Bones	70486	70487	70488
<input type="checkbox"/> Soft Tissue Neck	70490	70491	70492
<input type="checkbox"/> Spine: Cervical ___ w/ 3D (+76376)	72125	72126	72127
<input type="checkbox"/> Spine: Thoracic ___ w/ 3D (+76376)	72128	72129	72130
<input type="checkbox"/> Spine: Lumbar ___ w/ 3D (+76376)	72131	72132	72133
<input type="checkbox"/> Chest	71250	71260	71270
<input type="checkbox"/> Abdomen Only	74150	74160	74170
<input type="checkbox"/> Pelvis Only ___ w/ 3D Bony only (+76376)	72192	72193	72194
<input type="checkbox"/> Abdomen & Pelvis: ___ yes oral contrast ___ no oral contrast	74176	74177	74178
<input type="checkbox"/> CT Urogram	74176	74177	74178
<input type="checkbox"/> Stone Protocol (no oral, no IV contrast)	74176	74177	74178
<input type="checkbox"/> Upper Extremity: (R / L _____) ___ w/ 3D (+76376)	73200	73201	73202
<input type="checkbox"/> Lower Extremity: (R / L _____) ___ w/ 3D (+76376)	73700	73701	73702
<input type="checkbox"/> Other:			
MRI	wo IV	w IV	w & wo IV
<input type="checkbox"/> Brain <input type="checkbox"/> IAC	70551	70552	70553
<input type="checkbox"/> Orbit <input type="checkbox"/> Face <input type="checkbox"/> Sinus <input type="checkbox"/> Neck	70540	70542	70543
<input type="checkbox"/> Pituitary	70551	70552	70553
<input type="checkbox"/> Spine: Cervical	72141	72142	72156
<input type="checkbox"/> Spine: Thoracic	72146	72147	72157
<input type="checkbox"/> Spine: Lumbar	72148	72142	72158
<input type="checkbox"/> Chest	71550	72551	71552
<input type="checkbox"/> Abdomen: <input type="checkbox"/> Kidney <input type="checkbox"/> Adrenal <input type="checkbox"/> MRCP	74181	74182	74183
<input type="checkbox"/> Brach.Plex. R / L <input type="checkbox"/> Humerus R / L <input type="checkbox"/> Forearm R / L <input type="checkbox"/> Hand R / L	73218	73219	73220
<input type="checkbox"/> Shoulder R / L <input type="checkbox"/> Elbow R / L <input type="checkbox"/> Wrist R / L	73221	73222	73223
<input type="checkbox"/> Pelvis	72195	72196	72197
<input type="checkbox"/> Hip R / L <input type="checkbox"/> Knee R / L <input type="checkbox"/> Ankle/Mid/Hindfoot R / L	73721	73722	73723
<input type="checkbox"/> Femur R / L <input type="checkbox"/> Tib/Fib R / L <input type="checkbox"/> Mid/Foreft R / L <input type="checkbox"/> Foreft/Toes R / L	73718	73719	73720
MRA	wo IV	w IV	w & wo IV
<input type="checkbox"/> Head: <input type="checkbox"/> Venous	70544	70545	70546
<input type="checkbox"/> Neck	70547	70548	70549
<input type="checkbox"/> Arterial		71554	71555
<input type="checkbox"/> Mesenteric <input type="checkbox"/> Venous		74184	74185
<input type="checkbox"/>			
MAMMOGRAPHY			
<input type="checkbox"/> Screening Digital Mammo ___ Bilateral ___ Right ___ Left			77067
<input type="checkbox"/> Diagnostic Digital Mammo ___ Bilateral ___ Right ___ Left			77065 / 77066
<input type="checkbox"/> Other:			

ULTRASOUND	
<input type="checkbox"/> Carotid	93880
<input type="checkbox"/> Thyroid <input type="checkbox"/> Neck	76536
<input type="checkbox"/> Soft Tissue _____ (Body Part)	76536
<input type="checkbox"/> Scrotum	76870
<input type="checkbox"/> Retro CMP. ___ (renal/aorta) ___ (renal/bladder)	76770
<input type="checkbox"/> Retro LTD. ___ (renal) ___ (aorta)	76775
<input type="checkbox"/> Breast: ___ Bilateral ___ Right ___ Left	76641
<input type="checkbox"/> Abdomen: ___ Complete ___ Limited: ___ RUQ Organ _____	76700 / 76705 / 76706
<input type="checkbox"/> Pelvic/Transabdominal ___ M ___ F	76856
<input type="checkbox"/> Pelvic/Transvaginal	76830
<input type="checkbox"/> Bladder	76857
<input type="checkbox"/> Venous: ___ Bilateral ___ Right ___ Left ___ Upper ___ Lower	93970 / 93971
<input type="checkbox"/> Arterial: ___ Bilateral ___ Right ___ Left ___ Upper ___ Lower ___ w/ABI	93925 / 93926
<input type="checkbox"/> Echocardiogram <i>Cooper Only</i> : <input type="checkbox"/> BIOPSY: ___ Breast ___ Thyroid	93306

XRAY	
<input type="checkbox"/> CXR: PA & LAT	
<input type="checkbox"/> Bone Age Study	77072
<input type="checkbox"/> Abdomen/KUB	74018 / 74019 / 74021
<input type="checkbox"/> Shoulder R / L	73030
<input type="checkbox"/> Hip R / L	73502 / 73521
<input type="checkbox"/> Ankle R / L	73610
<input type="checkbox"/> Elbow R / L	73080
<input type="checkbox"/> Wrist R / L	73100
<input type="checkbox"/> Hand R / L	73130
<input type="checkbox"/> Femur R / L	73552
<input type="checkbox"/> Knee R / L	73562
<input type="checkbox"/> Tib/Fib R / L	73590
<input type="checkbox"/> Foot R / L	73630
<input type="checkbox"/> Spine: Thoracic	72070
<input type="checkbox"/> Spine: Cervical	72040 / 72052
<input type="checkbox"/> Spine: Lumbar	72100
<input type="checkbox"/> Skull	70260
<input type="checkbox"/> Sinus	70220
<input type="checkbox"/> Ribs	71101 / 71111
<input type="checkbox"/> Pelvis	72170
<input type="checkbox"/> Other:	

BONE DENSITY	
<input type="checkbox"/> 77078 Bon mineral density	<input type="checkbox"/> 93000 EKG