



HOME HEALTH RADIOLOGY SERVICES

"A Better Portable Service" For New Jersey's Visiting Physicians

View X-Rays and Reports at <http://portableservice.com>

Phones: (908) 264-9869
(888) 964-0088 · (908) 445-4246
Fax: (866) 498-0867

P.O. Box 2092 Union NJ 07083

Download Adobe Reader XI to complete, save and submit this form right on your computer -- [CLICK HERE](#)

Gender M F

PLEASE PRINT CLEARLY! Date Requested _____ Date Completed _____

Patient Name _____ Date Of Birth/Age _____

Phone _____ Social Security Number _____ Medicare Number _____

Facility Name _____ Phone _____ Fax _____

Address _____ City State Zip _____

Ordering Provider _____ NPI Number _____ Phone _____

Fax _____ Address _____

X-RAYS (Please check the specific body part to be examined) and EKGs

CHEST	Code	LOWER EXTREMITIES	Code	UPPER EXTREMITIES	Code
<input type="checkbox"/> Chest AP	71010	<input type="checkbox"/> Bilateral Hip	73520	<input type="checkbox"/> Clavicle L R	73000
<input type="checkbox"/> Chest AP & LAT	71020	<input type="checkbox"/> Hip L R	73510	<input type="checkbox"/> Scapula L R	73010
<input type="checkbox"/> Chest Lordotic	71021	<input type="checkbox"/> Femur L R	73550	<input type="checkbox"/> Shoulder L R	73030
<input type="checkbox"/> Ribs L R	71101	<input type="checkbox"/> Knee AP LAT L R	73560	<input type="checkbox"/> Humerus L R	73060
<input type="checkbox"/> Ribs Bilateral	71111	<input type="checkbox"/> Tibia Fibula L R	73590	<input type="checkbox"/> Elbow L R	73080
<input type="checkbox"/> Sternum	71130	<input type="checkbox"/> Ankle L R	73610	<input type="checkbox"/> Forearm L R	73090
		<input type="checkbox"/> Foot L R	73630	<input type="checkbox"/> Wrist L R	73110
		<input type="checkbox"/> Heel L R	73650	<input type="checkbox"/> Hand L R	73130
		<input type="checkbox"/> Toes L R	73660	<input type="checkbox"/> Fingers L R	73140
HEAD AND NECK	Code	SPINE AND PELVIS	Code	ABDOMEN	Code
<input type="checkbox"/> Nasal Bones	70160	<input type="checkbox"/> Thoracic	72070	<input type="checkbox"/> KUB	74000
<input type="checkbox"/> Sinuses	70220	<input type="checkbox"/> Cervical 2V	72050	<input type="checkbox"/> Obstructive Series	74022
<input type="checkbox"/> Skull	70260	<input type="checkbox"/> Lumbar 2V	72050		
<input type="checkbox"/> Facial Bones	70150	<input type="checkbox"/> Lumbar 4V	72110	CARDIOLOGY	Code
<input type="checkbox"/> Orbit	70200	<input type="checkbox"/> Pelvis	72170	<input type="checkbox"/> EKG	93000
<input type="checkbox"/> Mandible	70100	<input type="checkbox"/> Sacroiliac	72202	<input type="checkbox"/> Long Rhythm	93000
		<input type="checkbox"/> Sacrum & Coccyx	73630		

Ultrasound Examinations

VENOUS DUPLEX WITH DOPPLER	ABDOMINAL SURVEY	ULTRASOUND EXAM PREPARATIONS
<input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Both Legs	<input type="checkbox"/> Complete Abdominal	<input type="checkbox"/> Abdominal Survey: OK to drink water. No eating for 4 to 6 hours prior to exam
<input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Both Arms	ATT: _____	
ARTERIAL DUPLEX WITH DOPPLER	<input type="checkbox"/> Aorta Duplex	<input type="checkbox"/> Pelvic / Bladder: OK to drink water. Drink 4 to 8 glasses of water prior to exam even if ordered with abdominal ultrasound
<input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Both Legs	<input type="checkbox"/> Renal	
<input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Both Arms	<input type="checkbox"/> Bladder	
	<input type="checkbox"/> KUB	
CAROTID DUPLEX	<input type="checkbox"/> Renal Artery	
IN-HOME SLEEP APNEA TEST	HOLTER	
	ECHOCARDIOGRAPHY	

REASON FOR EXAM / DIAGNOSIS CODE: _____

I authorize the release of any medical information necessary to process this claim. Signature _____ Date _____