HOME HEALTH RADIOLOGY SERVICES

Better Portable Service" For New Jersey's Visiting Physicians
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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
☐ Chest AP	71045
☐ Chest AP & LAT	71046
☐ Chest Lordotic	71046
☐ Ribs L R	71101
☐ Ribs Bilateral	71111
☐ Sternum	71130

LOWER EXTREMITIES	Code
☐ Bilaterial Hip	73520
☐ Hip L R	73502
☐ Femur L R	73550
☐ Knee AP LAT L R	73560
☐ Tibia Fibula L R	73590
☐ Ankle L R	73610
☐ Foot L R	73630
☐ Heel L R	73650
☐ Toes L R	73660

UPPER EXTREMITIES	Code
☐ Clavicle L R	73000
☐ Scapula L R	73010
☐ Shoulder L R	73030
☐ Humerus L R	73060
☐ Elbow L R	73080
☐ Forearm L R	73090
☐ Wrist L R	73110
☐ Hand L R	73130
☐ Fingers L R	73140

HEAD AND NECK	Code
☐ Nasal Bones	70160
☐ Sinuses	70220
☐ Skull	70260
☐ Facial Bones	70150
☐ Orbit	70200
☐ Mandible	70100

SPINE AND PELVIS	Code
☐ Thoratic	72070
☐ Cervical 2V	72050
☐ Lumbar 2V	72050
☐ Lumbar 4V	72110
☐ Pelvis	72170
☐ Sacroiliac	72202
☐ Sacrum & Coccyx	72220

ABDOMEN	Code
☐ KUB/Abdomen	74018
☐ Obstructive Series	74022

CARDIOLOGY	Code
☐ EKG	93000
☐ Long Rhythm	93000

Ultrasound Examinations

VENOUS DUPLEX WITH DOPPLER

☐ Right Leg ☐ Left Leg ☐ Both Legs
☐ Right Arm ☐ Left Arm ☐ Both Arms

ARTERIAL DUPLEX WITH DOPPLER

☐ Right Leg ☐ Left Leg ☐ Both Legs
☐ Right Arm ☐ Left Arm ☐ Both Arms

☐ **CAROTID DUPLEX**
☐ **IN-HOME SLEEP APNEA TEST**

ABDOMINAL SURVEY

☐ Complete Abdominal
ATT: _____
☐ Aorta Duplex
☐ Renal
☐ Bladder
☐ KUB
☐ Renal Artery

☐ **HOLTER**
☐ **ECHOCARDIOGRAPHY**

ULTRASOUND EXAM PREPARATIONS

☐ **Abdominal Survey:** OK to drink water. No eating for 4 to 6 hours prior to exam

☐ **Pelvic / Bladder:** OK to drink water. Drink 4 to 8 glasses of water prior to exam even if ordered with adbominal ultrasound

REASON FOR EXAM / DIAGNOSIS CODE: _____

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