COVINGTON TRACE ER & HOSPITAL

4107 LA-59, Mandeville, LA 70471
Phone: 985-951-3650 | Fax: 985-951-3659
Email: frontdesk@covingtonhospital.com

Request for Outpatient Services

Patient Information

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Primary Phone Number:** _____

Name of Insurance Provider/ Policy #: _____

Pre-Certification: ◯ **Not Required** ◯ **In Progress** ◯ **Completed** **Pre-Cert/Authorization #**_____ **CPT #** _____

Reason for Test

REASON FOR THE TEST MUST BE GIVEN (Please DO NOT USE "Rule Out" or "Possible/Probable?")
ICD codes AND diagnostic information must be provided for EACH test ordered

_____

Outpatient Testing or Procedure Order Reason/Diagnosis: _____
ICD Code(s): _____

Order/ Results *Orders are valid for 90 days*

Requested Test Date: _____ ◯ ROUTINE at patient's convenience ◯ URGENT w/in 48 hours ◯ STAT

Results: ◯ Fax results _____ ◯ Call results _____

X-Ray	☐ Other (specify):
CT ☐ Oral Contrast ☐ W/ IV Contrast ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Head/Brain ☐ Neck (Soft Tissues) ☐ Pelvis ☐ Chest ☐ Sinus ☐ Cervical Spine ☐ Chest ☐ Abdomen ☐ Lumbar Spine ☐ Thoracic Spine (☐L) (☐R) (☐Bilat.) ☐ Extremity (specify):_____ (☐Upper) (☐Lower) ☐ Other (specify):_____ Creatinine:_____ GFR:_____ Date:_____
MRI ☐ W/O Contrast ☐ W/ and W/O IV Contrast	☐ Carotid MRA ☐ Brain MRI ☐ Pelvis ☐ Coccyx ☐ Brain MRA ☐ Neck (Soft Tissues) ☐ Sacrum ☐ IACs ☐ Lumbar Spine ☐ Cervical Spine ☐ Foot L / R ☐ Wrist L / R ☐ Thoracic Spine ☐ Shoulder L / R ☐ Hand L / R ☐ Knee L / R ☐ Orbits ☐ Elbow L / R ☐ Hip L / R ☐ Ankle L / R ☐ if claustrophobic ☐ Upper Arm Non-Joint L / R ☐ Lower Arm Non-Joint L / R ☐ Upper Leg Non-Joint L / R ☐ Lower Leg Non-Joint L / R ☐ Other (specify):_____ Creatinine:_____ GFR:_____ Date:_____
	☐ Abdomen (specify): (☐Liver) (☐Kidneys) (☐MRCP)
Ultrasound	☐ Other (specify):
Other Services	☐ Other (specify):

Physician Information:

Referring Practitioner Name: _____ NPI #: _____
Phone Number: _____ Fax Number: _____
Physician Signature: _____ Date: _____

Notice: Covington Trace ER & Hospital is unable to bill Medicare, Medicaid for services rendered.