



4107 LA-59, Mandeville, LA 70471
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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	<input type="checkbox"/> Other (specify): _____
CT	<input type="checkbox"/> Head/Brain <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Oral Contrast <input type="checkbox"/> Sinus <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> W/ IV Contrast <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Thoracic Spine (<input type="checkbox"/> L) (<input type="checkbox"/> R) (<input type="checkbox"/> Bilat.) <input type="checkbox"/> W/O Contrast <input type="checkbox"/> Extremity (specify): _____ (<input type="checkbox"/> Upper) (<input type="checkbox"/> Lower) <input type="checkbox"/> W/ and W/O IV Contrast <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
MRI	<input type="checkbox"/> Carotid MRA <input type="checkbox"/> Brain MRI <input type="checkbox"/> Pelvis <input type="checkbox"/> Coccyx <input type="checkbox"/> W/O Contrast <input type="checkbox"/> Brain MRA <input type="checkbox"/> Neck (Soft Tissues) <input type="checkbox"/> Sacrum <input type="checkbox"/> IACs <input type="checkbox"/> W/ and W/O IV Contrast <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Foot L / R <input type="checkbox"/> Wrist L / R <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Shoulder L / R <input type="checkbox"/> Hand L / R <input type="checkbox"/> Knee L / R <input type="checkbox"/> Orbits <input type="checkbox"/> Elbow L / R <input type="checkbox"/> Hip L / R <input type="checkbox"/> Ankle L / R <input type="checkbox"/> if claustrophobic <input type="checkbox"/> Upper Arm Non-Joint L / R <input type="checkbox"/> Lower Arm Non-Joint L / R <input type="checkbox"/> Upper Leg Non-Joint L / R <input type="checkbox"/> Lower Leg Non-Joint L / R <input type="checkbox"/> Other (specify): _____ Creatinine: _____ GFR: _____ Date: _____
Ultrasound	<input type="checkbox"/> Abdomen (specify): (<input type="checkbox"/> Liver) (<input type="checkbox"/> Kidneys) (<input type="checkbox"/> MRCP)
Other Services	<input type="checkbox"/> 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.

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