



HNMPPO

**PATIENT NAME:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_  
Last First MI  
**PHONE** Day: \_\_\_\_\_ Night: \_\_\_\_\_ **ALLERGIES:** \_\_\_\_\_

**\*\*DIAGNOSES:\*\***

**\*\*DIAGNOSES:\*\***

1. \_\_\_\_\_ 2. \_\_\_\_\_

**OTHER EXAM OR INSTRUCTIONS:**

**STAT Order:**

**CALL Report to Dr.:**

We cannot accept signature stamps. **DR. FAX #:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Time:** \_\_\_\_\_

Xray	CPT Code
___ Scoliosis Series	72090
___ Skull	72050
___ Bone Age Study	77072
___ Skeletal Survey	77075
___ Chest xray 2-view	71020
___ KUB	74000
___ Soft Tissue Neck	70360
___ Elbow complete <input type="checkbox"/> R <input type="checkbox"/> L	73080
___ Forearm 2-view <input type="checkbox"/> R <input type="checkbox"/> L	73090
___ Hand complete <input type="checkbox"/> R <input type="checkbox"/> L	73130
___ Femur 2-view <input type="checkbox"/> R <input type="checkbox"/> L	73550
___ Knee complete <input type="checkbox"/> R <input type="checkbox"/> L	73564
___ Tib/Fib 2-view <input type="checkbox"/> R <input type="checkbox"/> L	73590
___ Ankle complete <input type="checkbox"/> R <input type="checkbox"/> L	73610
___ Foot complete <input type="checkbox"/> R <input type="checkbox"/> L	73630
___ Pelvis	72170
___ Hip (2-views) <input type="checkbox"/> R <input type="checkbox"/> L	73510
___ Cervical Spine	72040
Ultrasound	CPT Code
___ Spine	76800
___ Hip	76885
___ Head	76506
___ Abdomen	76700
___ Scrotum/testicular	76870
___ Breast	76645
___ Pelvic complete	76856
___ Transvaginal	76830
CT	CPT Code
___ Head/Brain w/o contrast	70450
___ Abdomen with contrast	74160
___ Pelvis with contrast	72193
___ Neck w/o	70490
___ C-Spine w/o	72125
___ T-Spine w/o	72128
___ L-Spine w/o	72131

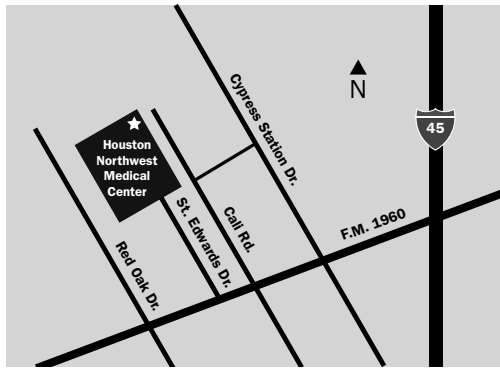
MRI	CPT Code
___ Brain w/wo	70553
___ Extremity Joint w/o ___ up	73221
___ Lower	73221
Specify _____	
___ Ext. long bone w/o ___ up	73218
___ Lower	73218
Specify _____	
___ Light sedation with valium	
___ Moderate sedation	
___ Sedation with anesthesia	
Cardiopulmonary	CPT Code
___ Echocardi.	93307 93320 93325
___ EKG	93005
Nuclear Medicine	CPT Code
Bone Scan	
___ Whole body	78306
___ 3 Phase	78315
___ Limited	78300
___ with spect	78320
Fluoro	CPT Code
___ Barium enema	74280
___ Upper GI	74247
___ UGI with SBF	74249
___ IVP	74410
___ Barium Swallow	74230
Laboratory Services	CPT Code
Sweat Chloride	
___ Collection	89230
___ Chloride test	82438
___ T. Billi	82247
___ Clinitek Glucose	84377
___ PKU	99001

Laboratory Services (con't)	CPT Code
___ PKU Capillary Collection	36416
___ Stool Reducing Substance	84377
___ Stool PH	83986
___ Stool Culture	87045
___ Stool O&P	87177
___ BMP	80048
___ CMP	80053
___ CBC with diff	85025
___ Basic fluid balance panel	80048
___ Blood Culture	87040
Diabetes Education	CPT Code
___ Initial RN	G0108
Initial skills and assessment	
___ MNT initial assessment	97802
Meal Planning RD	
___ MNT reassessment (group)	G0271
Additional need for RD	
___ MNT reassessment indiv same year	G0270
Complications/complex needs for RD	
___ MNT reassessment	97803
Individual basis follow up	
Rehabilitative Services	CPT Code
___ Occ Therapy Eval	97003
___ Physical Therapy Eval	97001
___ Speech Therapy Eval/Language	922507
___ Speech Therapy Eval/Swallow	92610
EEG	CPT Code
___ Awake (routine)	95819
___ Sleep (sleep deprived)	95816
___ EEG Eval	95824
Sleep Disorder	CPT Code
___ Nocturnal Polysomnography	95810
___ CPAP Trial	95811
___ Multiple Sleep Latency	95805
___ Maintenance of Wakefulness	95805

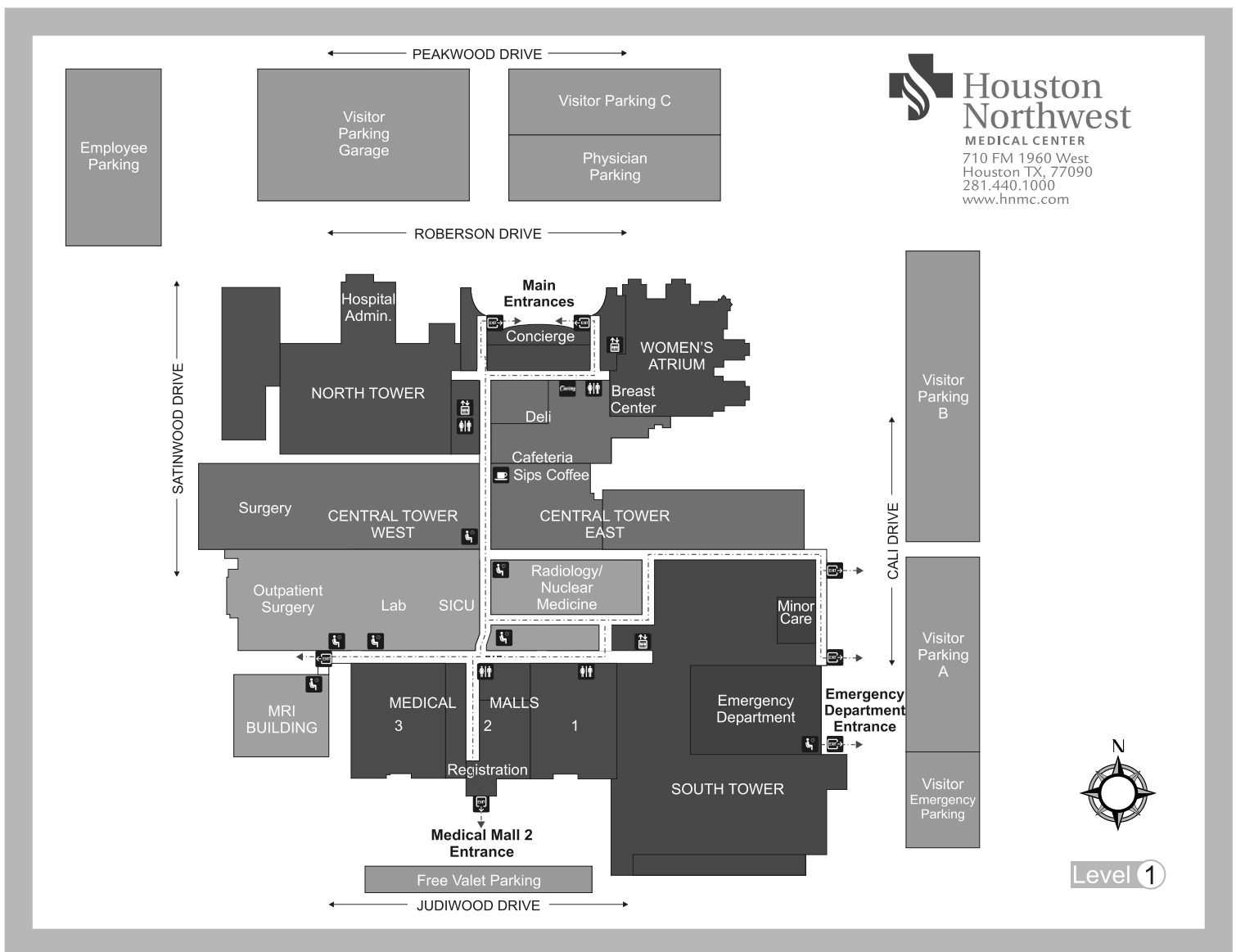
**VO/TO**  
**Read Back**

**XRAY51 PEDIATRIC**

Patient Label



Medicare regulations require the tests to be medically necessary for the diagnosis and treatment of the patient to qualify for reimbursement from the program. The physician must be treating the patient in connection with the diagnosis or complaints listed and this information must accurately reflect the medical reasons for requesting these tests. The medical necessity of each test ordered on this requisition must be documented in the patient's medical record. Tests ordered for the purpose of screening, or which the physician believes to be appropriate even if the payor may not allow reimbursement, may not be billed to Medicare except for the purpose of receiving a denial. An Advance Beneficiary Note (ABN) must be signed by the beneficiary or authorized person and attached to this form indicating his/her willingness to assume financial responsibility for the testing. General Instructions for Governmental Payors: All orders for medical imaging tests must include a statement of the medical reason for those tests. Please list the reason(s) for the exam below. If a specific test is not supported by documentation in the medical record or is clearly for screening purposes, the test must be designated as a "Screening Test" and must be accompanied by the signed ABN.



**\*DIRECTIONS AND MAP NOT PART OF MEDICAL RECORD.\***