



MED HEALTH SERVICES

2490 Mosside Boulevard
Monroeville, PA 15146
T/412.373.7125 F/412.373.6861



DATE: _____

NO SHOW

TECHNICIAN: _____

PATIENT INFO

LAST NAME: _____

FIRST NAME: _____ MI: _____

SS#: _____ DOB: _____

SEX: M F PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BILLING

PRE-AUTHORIZATION NEEDED YES NO

REFERRAL NEEDED YES NO

INSURANCE VERIFIED BY: _____

PRE-AUTHORIZATION/REFERRAL NO. _____

REFERRING PHYSICIAN INFO

PHYSICIAN: _____

PHONE: _____ FAX: _____

NPI #: _____

DR. SIGNATURE _____

NUCLEAR MEDICINE

CARDIAC NUCLEAR STRESS TEST

(78465, 78478, 78480, 78481, 93015, 90780)

SPECT S/R Myocardial Perfusion P.O.
(78465)

Myocardial Perfusion With Wall Motion
(78478)

Myocardial Perfusion With Ejection Fraction
(78480)

First Pass
(78481)

Treadmill
(93015)

IV Infusion
(96374)

MUGA With Rhythm Strip

(78472, 93040)

RADIO-PHARMACEUTICALS

TC ⁹⁹Cardiolite (1-30mCi) Rest: 15 Stress: 25
(A9502)

PHARMACOLOGICAL AGENTS

Adenosine (Bill Per 6mg) Actual dose given: _____ mg
(J0152)

INSURANCE INFO

MEDICARE MEDICAID BC/BS HMO COMM SP

Insurance Name: _____

Policy Holder Name: _____ DOB: _____

Policy Holder Social Security #: _____ Relationship to Patient: _____

Policy Holder Address: _____

Policy ID#: _____ Group #: _____ Insurance Phone #: _____

Insurance Address: _____

Secondary Insurance Name: _____ Policy #: _____ Group #: _____

Responsible Party Name: _____ DOB: _____

Responsible Party Address: _____

Responsible Party Social Security #: _____ Relationship to Patient: _____

I request that payment of authorized Medicare/Insurance benefits be made to MHS for any services furnished to me by that provider of service. I authorize any Holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information's needed to determine these benefits Payable for related service. I understand I will be responsible for payment of deductible, co-pay, co-insurance and/or non-covered services within 45 days after determination of insurance carrier.

Patient / Responsible party
Signature: _____ Date _____

SYMPTOMS/CLINICAL HISTORY

PRIMARY ICD9 DIAGNOSIS CODES (Physician Must Select One)

- V45.82 PTCA (Percutaneous Transluminal Coronary Angio)
- 411.81 Coronary Occlusion w/o Myocardial Infarction
- 412 Old Myocardial Infarction
- 413.9 Anglna Pectoris
- 414.9 Ischemic Heart Disease, Chronic
- 426.3 Left Bundle Branch Block
- 427.31 Atrial Fibrillation
- 428.1 Left Heart Failure
- 794.30 Abnormal Function Study, Unspecified
- 411.0 Post-myocardial Infarction
- 414.00 Coronary Atherosclerosis
- 426.4 Right Bundle Branch Block
- 428.0 Congestive Heart Failure
- 425.4 Cardiomyopathy
- 794.31 Abnormal Electrocardiogram
- Other _____

SECONDARY ICD9 DIAGNOSIS CODES

- V45.81 Aortocoronary Bypass Post-Surgery
- 780.2 Syncopy & Collapse
- 786.59 Chest Pain, Unspecified
- 242.0 Hypercholesterolemia
- 401.9 Hypertension
- 780.4 Dizziness
- 786.05 Shortness of Breath
- 250.00 Diabetes Mellitus
- Other _____

TECHNICIAN NOTES

Family History: CAD Other _____
HTN
DM