



MED HEALTH SERVICES

2490 MOSSIDE BOULEVARD
MONROEVILLE, PA 15146
TEL/ 412.373.7125 FAX/ 412.373.6861



DATE: _____

TECHNICIAN: _____

INSURANCE VERIFIED BY: _____

PATIENT INFO

Last Name, First Name:		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
Date of Birth:	Social Security #:	
Patient Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	

FACILITY INFO

Facility/Office:		
Nurse Station:	Room #:	
Street Address:		
City:	State:	Zip:
Phone:	Fax:	

REFERRING PHYSICIAN INFO

DR.: _____ NPI#: _____

PHONE: _____ FAX: _____

ULTRASOUND TESTING ORDER

<input type="checkbox"/> Abdomen + Renal + Aorta Duplex (76700 76770 93978)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Abdominal (screening) (76700)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Right Upper Quadrant or _____ organ (76705)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Aorta Duplex Scan (93978)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Renal + Renal Artery Duplex (76770 93975)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Renal (76770)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Superior Mesenteric Artery Duplex (93975)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Pelvic Female / Male (prostate & bladder) (76856)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Pelvic Limited (bladder) (76857)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Thyroid / Parathyroid (76536)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Carotid Duplex (93880)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Echocardiogram (rule out congenital heart disease) (93303 93320 93325)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Echocardiogram (93306 93320 93325)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Venous Upper Extremities _____ bilateral _____ unilateral (93965) (93970) (93971)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Venous Lower Extremities _____ bilateral _____ unilateral (93965) (93970) (93971)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Arterial Upper Extremities _____ bilateral _____ unilateral (93923) (93930) (93931)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Arterial Lower Extremities _____ bilateral _____ unilateral (93923) (93925) (93926)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Testicular w/Arterial Doppler (76870 93975)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Testicular (76870)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Other Vascular Doppler (93975)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Vascular Duplex for Portal HTN (93975)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Soft Tissue Sonography (76880)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> DX: _____

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

INJURY: _____ INJURY DATE: _____

DIAGNOSTIC TESTING ORDER

<input type="checkbox"/> EKG (93000)	<input type="checkbox"/> DX: _____
<input type="checkbox"/> Holter Monitor 24 hour (93230)	<input type="checkbox"/> DX: _____

ELECTRO-DIAGNOSTIC TESTING ORDER

<input type="checkbox"/> NCV Motor (95861) (95864)	Arm RT _____ LT _____	Leg RT _____ LT _____	Total _____	
<input type="checkbox"/> With F-Wave (95903)	Arm RT _____ LT _____	Leg RT _____ LT _____	Total _____	
<input type="checkbox"/> Sensory (95904)	Arm RT _____ LT _____	Leg RT _____ LT _____	Total _____	
<input type="checkbox"/> Needle EMG	1 Ext (95860)	2 Ext (95861)	3 Ext (95863)	4 Ext (95864)
<input type="checkbox"/> H - Reflex (95934)	# of Nerves _____			
<input type="checkbox"/> H - Reflex Gastro (95936)	_____			
<input type="checkbox"/> OTHER	_____			

Facility Signature: _____ Dr. Signature: _____