TO ORDER CALL:
PHONE (469) 269-6894 | **FAX** (469) 299-4546
EMAIL support@mobilemedimaging.org | www.mobilemedimaging.net

ULTRASOUND ORDER FORM

Patient Information:

Service Date: ____/____/____ ID #: ______________ Ordering Date___/___/___

Name____ D.O.B.___/___/___ SS#____________________ ☐ Male ☐ Female

Address______________________________________City______________ State____ Zip_______Phone (____)_____-_______

Primary Insurance___________________________ Insurance ID #____

Secondary Insurance_________________________ Insurance ID #____

Facility_____________________________

☐ **Lower Extremity Venous B/L • 93970**
☐ **Lower Extremity Venous U/L • 93971**

Diagnosis code_________________
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☐ **Upper Extremity Venous B/L • 93970**
☐ **Upper Extremity Venous U/L • 93971**

Diagnosis code_________________
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☐ **Lower Extremity Arterial B/L • 93925**
☐ **Lower Extremity Arterial U/L • 93926**

Diagnosis code_________________
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☐ **Upper Extremity Arterial B/L • 93930**
☐ **Upper Extremity Arterial U/L • 93931**

Diagnosis code_________________
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☐ **Renal /Kidney /Aorta • 76770 • 76775**

Diagnosis code_________________
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☐ **Renal Doppler • 93975 • 93976**

Diagnosis code_________________
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☐ **Full Aorta/AAA • 76706**

Diagnosis code_________________
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☐ **Abdominal Ultrasound • 76700 • 76705**

Diagnosis code_________________
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☐ **Echocardiogram • 93306**

Diagnosis code_________________
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☐ **Pelvic Ultrasound • 76856**
☐ **Pelvic Ultrasound Non OB • 76857**

Diagnosis code_________________
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☐ **Pelvic Ultrasound Male • 76872**
☐ **Scrotal • 76870** ☐ **Bladder • 76775**

Diagnosis code_________________
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☐ **Thyroid • 76536**

Diagnosis code_________________
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☐ **Carotid • 93880 • 93882**

Diagnosis code_________________
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☐ **Other**

Diagnosis code_________________
____

Requesting Physician:

Name_________________________________ NPI#________________________________ Fax Results To (____)_____-_______

I certify that the above ordered tests are medically necessary for this patient.

Physician's Signature: ____