Prescription and Referral Form

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name** | | |  | | | | | **Date** | |  |
| X-ray Number (for tech use) | | |  | | | | | **DOB** | |  |
| **Medicare Charting?** | | | Y / N | | | | | **M or F** | |  |
| **Referring Dr.** | | |  | | | | | Fax # | |  |
| **Facility** | | |  | | | | | Fax # | |  |
| **Diagnosis** | | |  | | | | | | | |
|  | | |  | | | | | | | |
| Exams Ordered: | | |  | | | | Number of Views: | |  | |
|  | | |  | | | |  | |  | |
|  | | |  | | | | | | | |
| Portable Radiology is indicated for this patient due to: | | | | | | | | | | |
|  | | | | | | | | | | |
|  | Geographical (rural) location, limited or no access to alternative source. Stationary unit unavailable. | | | | | | | | | |
|  | Physical limitations of Patient | | | | | | | | | |
|  |  | | Patient is non-ambulatory | | | | | | | |
|  |  | | Patient requires assistance with transfers | | | | | | | |
|  |  | | Patient is resident of Nursing Home | | | | | | | |
|  |  | | Patient is unable to drive | | | | | | | |
|  |  | | Other: | | |  | | | | |
|  | | | |  | | | | | | |
|  | | | | |  | | | | | |
|  | |  | | |  | | | | | |
|  | |  | | | Physician Signature | | | | | |

**ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize the Insurance Company to pay directly to SCY Imaging, Inc. benefits due me, if any, by reason of services described in t he statement rendered and are provided for in the above policy contract with aforementioned Insurance Company. I will be responsible for all such charges in excess of whatever sum may be paid by the Insurance Company above mentioned. I authorize the release of any medical information necessary to process this claim.

MEDICARE PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SCY Imaging, Inc., for any services furnished me by that service. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it’s agents any information needed to determine these benefits payable for related services.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature Date