BIG SKY IMAGING

Phone: (855) 249.9729
Fax: (406) 206.5015

Please fill out and call for technologist

DATE:	PATIENT NAME: LAST FIRST	ROOM #	M	F	DOB

ORDERING Entity or Responsible Party:

ADDRESS:

CONTACT:

PHONE: **FAX:**

_____

nurses signature

Physician Signature: _____

ORDER:

_____

This patient would find it physically and/or psychologically taxing because of advanced age and/or physical limitations to receive an X-RAY outside this location. This test is medically necessary for the diagnosis and treatment of this patient.

UPPER EXTREMITIES	CPT
Clavical	73000
Scapula, Complete	73010
Shoulder 2+V	73030
Humerus 2V	73060
Elbow 2V	73070
Elbow 3V	73080
Forearm 2V	73090
Wrist 2V	73100
Wrist, Complete 3+V	73110
Hand 2V	73120
Hand 3+V	73130
Finger(s) 2+V	73140

HEAD	CPT
Nasal Bones 3V	70160
Orbits 4V	70200
Sinus 3V	70220
Mandible 4V	70110

SPINE & PELVIS	CPT
Spine, Cervical 2-3V	72040
Spine, Cervical 3+V	72050
Spine, Thoracic 2V	72070
Spine, Lumbosacral 2V	72100
Pelvis, AP only	72170
Pelvis, AP/Inlet/Outlet	72190
Sacroiliac joints 3+V	72202
Sacrum & Coccyx 2+V	72220

CHEST	CPT
Chest 1V	71045
Chest 2V	71046
KUB	74018

HEAD Continued	CPT
Facial Bones, Partial	70140
<3V	70250
Skull <4 Views	

LOWER EXTREMITIES	CPT
Hips, Unilateral 2-3V	73502
Femur 2V	73552
Knee 2V	73560
Knee 3V	73562
Knee, Complete 4+V	73564
Tibia & Fibula, AP & Lat	73590
Ankle, AP & Lat	73600
Ankle, Complete	73610
Foot, AP & Lat	73620
Foot, Complete 3+V	73630
Calcaneus 2+V	73650
Toe(s) 2+V	73660

TRANSPORTATION	CPT
Trans. Portable, 1pt Trans	R0070
Portable, >1pt	R0075
Set-up Portable	Q0092
ECG	93000

MEDICARE #_____

MEDICAID #_____**STATE MT**

CO / OTHER INSURANCE_____

POLICY # _____

GROUP # _____

ADDRESS _____

NOTES: Symptoms / Brief History / Diagnoses

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR ANY INSURANCE BENEFITS BE MADE DIRECTLY TO BIG SKY MOBILE IMAGING, LLC., AND/OR THE INTERPRETING PHYSICIAN FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO ACKNOWLEDGE THAT ALL SERVICES MAY NOT BE COVERED IN FULL BY MY INSURANCE AND I WILL PAY IN FULL ANY BALANCE DUE TO BIG SKY MOBILE IMAGING, LLC.

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PATIENT'S SIGNATURE

***AGE 55 AND UNDER: I AM/AM NOT PREGNANT. IF YES, SHIELDING WAS USED WHEN POSSIBLE.**

DATE TAKEN	TIME	# OF PATIENTS THIS VISIT	# OF VIEWS	TECH INITIALS	RADIOLOGIST	
	AM / PM					R0070-Transport (1 pt) R0075-Transport (>1 pt) Q0092-setup