



MMDS of BOSTON

MOBILE MEDICAL DIAGNOSTIC SERVICES

48 Silver Lake Avenue, Newton, MA 02458

PHONE: 617-244-9729 FAX: 617-244-9730

617-244-XRAY

X-RAY ORDER REQUEST

Please fax requisition AND call the office

**X-RAY
EKG
ULTRASOUND
HOLTER**

Date of Service: _____ Caller: _____ Check if Stat: Check if after hours:

FACILITY: _____ Room# _____ FAX Report To: _____

**** MUST CHECK ONE: Skilled/PPS Medicare Part B Medicaid HMO Private Pay

Patient: _____ DOB: _____ SS# _____

(Legal name; must match Medicare card exactly)

Address (if private home) _____ MALE FEMALE

City and Phone Number (if private home) _____

MEDICARE # _____ MEDICAID # _____

SECONDARY/OTHER INSURANCE # _____ ORDERING CLINICIAN _____

Symptoms: (Reason for exam - cannot use "rule out" or "suspected". Please indicate SYMPTOMS ONLY): _____

Signature of Staff Member filling out request: _____ (no initials or abbreviations). Verbal/Phone Orders from Physicians are accepted only if by signature. Staff verifies that the appropriate signed physician's orders supporting medical necessity for all of the tests requested are on file at the facility.

- | | |
|--|---|
| 74010 <input type="checkbox"/> Abdomen | 74000 <input type="checkbox"/> KUB |
| 73610 <input type="checkbox"/> Ankle Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 72170 <input type="checkbox"/> Pelvis |
| 71010 <input type="checkbox"/> Chest (1-View) | 71110 <input type="checkbox"/> Ribs Lt <input type="checkbox"/> Rt <input type="checkbox"/> |
| 72220 <input type="checkbox"/> Coccyx / Sacrum | 73030 <input type="checkbox"/> Shoulder Lt <input type="checkbox"/> Rt <input type="checkbox"/> |
| 73080 <input type="checkbox"/> Elbow Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 72040 <input type="checkbox"/> Spine: Cervical C-Spine |
| 70150 <input type="checkbox"/> Facial Bones (3-View) | 72100 <input type="checkbox"/> Spine: Lumbar L-Spine |
| 70200 <input type="checkbox"/> Facial Orbital Study | 72070 <input type="checkbox"/> Spine: Thoracic T-Spine |
| 70110 <input type="checkbox"/> Facial Mandible (Jaw) | 70250 <input type="checkbox"/> Skull |
| 70220 <input type="checkbox"/> Facial Sinus | 73590 <input type="checkbox"/> Tibia/Fibula Lt <input type="checkbox"/> Rt <input type="checkbox"/> |
| 73550 <input type="checkbox"/> Femur Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 73660 <input type="checkbox"/> Toe(s) Lt <input type="checkbox"/> Rt <input type="checkbox"/> |
| 73140 <input type="checkbox"/> Finger(s) Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 73100 <input type="checkbox"/> Wrist Lt <input type="checkbox"/> Rt <input type="checkbox"/> |
| 73630 <input type="checkbox"/> Foot Lt <input type="checkbox"/> Rt <input type="checkbox"/> | Cardiology |
| 73090 <input type="checkbox"/> Forearm Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 93005 <input type="checkbox"/> EKG |
| 73120 <input type="checkbox"/> Hand Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 93230 <input type="checkbox"/> Holter Monitor |
| 73560 <input type="checkbox"/> Heel Lt <input type="checkbox"/> Rt <input type="checkbox"/> | Ultrasounds |
| 73510 <input type="checkbox"/> Hip Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 93306 <input type="checkbox"/> Echocardiogram |
| 73060 <input type="checkbox"/> Humerus Lt <input type="checkbox"/> Rt <input type="checkbox"/> | 93970 <input type="checkbox"/> Venous Doppler (DVT) |
| 73560 <input type="checkbox"/> Knee Lt <input type="checkbox"/> Rt <input type="checkbox"/> | <input type="checkbox"/> Other (please specify below) |

For Office Use Only:

Technologist Signature: _____

Trip # _____

Time: _____