



**MED HEALTH SERVICES
PITTSBURGH CARDIOVASCULAR INSTITUTE**

200 JAMES PLACE
MONROEVILLE, PA 15146
TEL/ 412.373.7125 FAX/ 412.373.6861



DATE: _____

TECHNICIAN: _____

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: _____

ULTRASOUND TESTING ORDER

- ___ **Abdomen + Renal + Aorta** (76705 76770 93978) DX: _____
- ___ **Abdominal** (76700) DX: _____
- ___ **Abdominal, Limited Organ:** _____ **Quad:** _____ DX: _____
- ___ **RUQ + Doppler** (75705) DX: _____
- ___ **Abdominal Aorta Duplex** (76705 93975) DX: _____
- ___ **Renal + Doppler + Bladder** (93978) DX: _____
- ___ **Renal + Doppler** (76770 93975 76857) DX: _____
- ___ **Renal + Doppler** (76770 93975) DX: _____
- ___ **Renal + Bladder** (76770 76857) DX: _____
- ___ **Renal (no doppler - no bladder)** (76770) DX: _____
- ___ **Bladder, Limited Pelvic** (76857) DX: _____
- ___ **Pelvic** (76856) DX: _____
- ___ **Prostate** (76856) DX: _____
- ___ **Thyroid** (76536) DX: _____
- ___ **Carotid Duplex** (93880) DX: _____
- ___ **Echocardiogram, Congenital Anomalies** (93303 93320 93325) DX: _____
- ___ **Echocardiogram, Non-Congenital Anomalies** (93306) DX: _____
- ___ **Venous Upper Extremities** ___ bilateral ___ unilateral (93965 93970) (93965 93971) DX: _____
- ___ **Venous Lower Extremities** ___ bilateral ___ unilateral (93965 93970) (93965 93971) DX: _____
- ___ **Arterial Upper Extremities** ___ bilateral ___ unilateral (93923 93930) (93923 93931) DX: _____
- ___ **Arterial Lower Extremities** ___ bilateral ___ unilateral (93923 93925) (93923 93926) DX: _____
- ___ **Testicular w/scrotal doppler** (76870 93975) DX: _____
- ___ **Testicular** (76870) DX: _____
- ___ **Other Vascular Doppler** (93975) DX: _____
- ___ **Venous Duplex for Reflux** (93970 93965) DX: _____
- ___ **Soft Tissue Sonography** (76881) DX: _____
- ___ **Other** _____ 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 and/or PCI and/or Oliver W. Caminos, MD and Associates for any services furnished to me by that provider of service. I authorize any holder of medical information to release on my behalf said information to any third party payer or its agents any and all medical information needed to determine these benefits. I understand I will be responsible for any deductible, co-pays, co-insurances, and/or any non-covered services within 45 days after determination of my insurance carrier.

Patient / Responsible party
Signature: _____ Date: _____

REFERRING PHYSICIAN INFO

DR.: _____ NPI #: _____
PHONE: _____ FAX: _____

SYMPTOMS/CLINICAL HISTORY

INJURY: _____ INJURY DATE: _____

DIAGNOSTIC TESTING ORDER

- ___ **EKG** (93000) DX: _____
- ___ **Holter Monitor 24 hour** (93230) DX: _____

ELECTRO-DIAGNOSTIC TESTING ORDER

- | | | | |
|--------------------------------------|---|-------------------------|-------------|
| ___ NCV Motor (95861) (95864) | Arm RT _____ LT _____ | Leg RT _____ LT _____ | Total _____ |
| ___ With F-Wave (95903) | Arm RT _____ LT _____ | Leg RT _____ LT _____ | Total _____ |
| ___ Sensory (95904) | Arm RT _____ LT _____ | Leg RT _____ LT _____ | Total _____ |
| ___ Needle EMG (95860) | 1 Ext _____ 2 Ext _____ 3 Ext _____ 4 Ext _____ | (95861) (95863) (95864) | |
| ___ H - Reflex (95934) | # of Nerves _____ | | |
| ___ H - Reflex Gastro (95936) | | | |
| ___ OTHER | | | |

Facility Signature: _____ Dr. Signature: _____