PPX
PROFESSIONAL PORTABLE X-RAY

Phone: 952-915-9779
Phone: 1-866-895-2119
Fax: 952-915-9597

PORTABLE SERVICE REQUISITION

PATIENT NAME: **FACILITY:**
DATE OF BIRTH:
SOCIAL SECURITY #
GENDER:
ROOM #: **PHONE / FAX:**

SERVICE REQUESTED INFORMATION

SERVICE DATE _____ **PRIORITY:** _____ **ORDERED BY:** _____

REFERRING PHYSICIAN: _____ **NPI:** _____

PROCEDURE(S): _____
REASON:

INSURANCE TYPE	PAYER NAME	HIC/SUBSCRIBER #	POLICY #/GROUP	PLAN
PRIMARY: (ie. Medicare/HMO)				
SECONDARY: (ie. supplement)				

MED A: Y / N / NA HOSPICE: Y / N / NA

RESPONSIBLE PARTY	ADDRESS 1	ADDRESS 2	CITY	ST	ZIP	PHONE

AUTHORIZED SIGNATURE _____
ordering practitioner that wants service performed portable

FOR TECHNOLOGIST AND OFFICE USE ONLY

ACCESSION #: _____ **PATIENT ID:** _____ **STUDY ID:** _____

PROCEDURE(S): _____

DIAGNOSTIC CODE(S): _____

TRANSPORTATION: (Total patients seen this trip.) _____ **# FILM / VIEWS:** _____ / _____

ARRIVAL DATE: _____ **TIME:** _____ **TECH SIGNATURE:** _____

CLINICAL NOTES: _____

PHONED TO: _____ **PH#:** _____ **DATE/TIME:** _____

ASSISTED BY: _____ **DEDUCTIBLE MET:** ____ **INS VERIFIED ON:** _____