harmonycares diagnostics

Radiology Exam Order Form

Phone: 800-759-7291 Fax: 248-269-0630

Today's Date: ___/___/_____

Referring Provider / Agency Information

Ordering Agency Name: _____

Referring Provider Name: _____

Phone: _____ Fax: _____ Email: _____

Street Address: _____ Suite (if applicable): _____

City: _____ State: _____ Zip: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Sex (assigned at birth): _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Street Address: _____ Apt. or Unit: _____

City: _____ State: _____ Zip: _____

Contact Name (if other than patient): _____ Phone: _____

Insurance Information

Name of Primary Insurance: _____ Group #: _____ Policy #: _____

Name of Policy Holder (if other than patient): _____

Name of Secondary Insurance: _____ Group #: _____ Policy #: _____

Name of Policy Holder (if other than patient): _____

Exam Information

Exam(s) needed (please be specific): _____

_____

Symptom(s) (please provide detail for each exam): _____

_____

Diagnosis or Condition Requiring Portable Exam (x-ray only): _____

_____

Ordering Provider Name (printed): _____

Phone: _____ Fax: _____

Signature (if written order is not signed): _____