



Request for Diagnostic Imaging Interpretation

Referring Dr.: _____
Dr. Phone: _____
Dr. Facsimile: _____

Film Handling

URGENT: Call Report
 Fax Report and Mail with Films

Patient Information

Name: _____
Street: _____
City/St/Zip: _____
Social Sec #: _____
Date of Birth: _____
Sex: Male Female
Onset Date: _____

Case Information

Payment Enclosed
 Bill Doctor
 HMO (*see instructions*)
 PPO / Health Insurance (*enclose copy of ins card*)
 PI/Auto MedPay
 PI Attorney Lien (***no unrepresented 3rd party***)
 Workers Compensation (*accepted cases only*)

Insurance Information

Company: _____
Billing Addy: _____
City/St/Zip: _____
Phone: _____
Policy/ID #: _____
Claim #: _____
Contact: _____

Attorney Information

Firm: _____
Attorney: _____
Street: _____
City/St/Zip: _____
Phone: _____
File #: _____
Contact: _____

For Doctors Use Only: Please list all relevant clinical information including Sx, history, and/or exam findings.

Diagnosis code(s) used for this patient: _____, _____, _____, _____, _____

Surgical and/or malignancy history? No Yes (please explain): _____

Clinical Information: _____

PATIENT READ AND SIGN

I understand that my doctor is submitting my imaging studies to NYCC Diagnostic Imaging for radiological evaluation. I also understand that the fee for such services will be submitted to my insurance company, healthcare carrier, attorney or worker's compensation carrier for payment. In the event my health coverage does not reimburse the fee in full, or if for any reason I do not have coverage for the submitted services, I am fully, personally responsible to NYCC Diagnostic Imaging for all fees.

Patient Signature: _____ Date: _____
(Parent if minor child)

Please have patient sign lien form if this is an attorney lien case.