RADIOLOGY OUTPATIENT REFERRAL FORM

1002 South Lincoln Street Knoxville, Iowa 50138

Phone (641) 842-1466 Fax (641) 842-1472 www.knoxvillehospital.org

X-RAY CT MRI US NUCLEAR MED/DEXA MAMMO EKG

PT. Name____ DOB________________

Address ______________________________City ____________State _____ Zip__________

Phone Number_______________ Cell Phone______________ Insurance________________

Date of Test_________ Time of Test_______ Physician Ordering Test___________________

Is it okay to leave a message if unable to contact ? ____________________ YES NO

Exam to be ordered:____

Reason for exam:____

Symptoms (If using "R/O" a symptom must be recorded):__________________________

Previous Imaging______________ YES NO Dr. Phone: ____________ Fax:__________

Date:_____________ Physician's Signature________________________________

INSURANCE VALIDATION/PRIOR AUTHORIZATION

Insured:______________________________ Employer_________________________________

Primary Insurance______________________ ID:_____________________________________

Secondary Insurance____________________ ID:________________________________

Tertiary Insurance______________________ ID:_________________________

Validator's Name______________________

PT. Name_____________________________ DOB_____________________________

Procedure Code______________________ Verification___________________ YES NO

Policy Effective Date_____________________ PAR/AIM__________________ YES NO

Ded:___________________________ Co-Insurance By:__________________ YES NO

Prep___________________________ Date:___________________

ALL FIELDS MUST BE FILLED OUT

ALL PRIOR AUTHORIZATIONS MUST BE DONE PRIOR TO SCHEDULING

Form Created 10-2009