

Date of Referral: <hr/> Name: (Last, First, MI) <hr/> Date of Birth: (MM/DD/YY) Phone #: <hr/> Insurance Name: _____ Policy Number: _____	____ Please Bill My Insurance INSURANCES CURRENTLY ACCEPTED: Medicare, Medicaid, Amerigroup Carefirst - Blue Cross/Blue Shield (No Hmos), Bravo - Elder Health, Tricare Aetna PPO Only (No Hmos) United Healthcare (All Plans), Coventry Health Care (All Plans), Other: _____ ____ PLEASE BILL MY ACCOUNT
---	---

Ultrasound Services of America, Inc



Head Office: 1401 MERCANTILE LANE, SUITE 200A, LARGO, MD 20774 PHONE: (301) 386-2223 FAX: (301) 386-2231

Service Requested:

- | | |
|--|--|
| <input checked="" type="checkbox"/> COMPLETE CARDIOVASCULAR ASSESSMENT | <input type="checkbox"/> PADOGRAM |
| <input type="checkbox"/> HEART 2-D ECHOCARDIOGRAM | <input type="checkbox"/> ABIGRAM |
| <input type="checkbox"/> CAROTID DUPLEX ULTRASOUND | <input type="checkbox"/> VASOGRAM |
| <input type="checkbox"/> OSTEOPOROSIS TEST | <input type="checkbox"/> ENDOGAMY |
| <input type="checkbox"/> SLEEP STUDY | <input type="checkbox"/> NERVE CONDUCTIONS |

Brief History, Diagnosis, Clinical History or Reason For Exam:

- | | |
|---|--|
| <input type="checkbox"/> Hypertension – 402.90 | <input type="checkbox"/> Heart Murmur – 343.00 |
| <input type="checkbox"/> Chest Pain – 786.50 | <input type="checkbox"/> CHF – 428.00 |
| <input type="checkbox"/> Abnormal EKG -794.31 | <input type="checkbox"/> Pre-Op Exam – V72.84 |
| <input type="checkbox"/> Syncope – 780.2 | <input type="checkbox"/> Irregular Heart Beat – 427.42 |
| <input type="checkbox"/> Menopause – 627.2 | <input type="checkbox"/> Osteoporosis – 733.0 |
| <input type="checkbox"/> COPD – 496 | <input type="checkbox"/> Sleep Disorder / Apnea |
| <input type="checkbox"/> History of Heart Attack or Stroke | |
| <input type="checkbox"/> 440.21- Atherosclerosis of the extremities with claudication | |
| <input type="checkbox"/> 250.70-250.73-Diabetes with peripheral circulatory disorders | |
| <input type="checkbox"/> 443.0-443.9-Other peripheral Vascular Disease | |

Other: (specify)

Number of Visits: _____ If Blank, 1 Visit is Assumed.	Authorization # (If Required)
--	-------------------------------

Company:

- Independent Diagnostics Testing Specialist

Referral is Valid Until: (Date) _____
(See Carrier Instructions)

Signature: (Individual Completing This Form)

Authorizing Signature: (If Required)