Golden Physicians Medical Group, Inc.

X-RAY DIRECT REFERRAL FORM

REQUEST DATE	REFERRING PROVIDER NAME	REFERRING PROVIDER TEL #

PATIENT NAME (FIRST, MI, LAST)	DOB

HEALTH PLAN	MEMBER ID #	ELIGIBILITY VERIFIED BY	DATE

REASON FOR REFERRAL

DIAGNOSIS	ICD-10

REFERRING PROVIDER SIGNATURE (MANDATORY – WILL NOT BE PROCESSED WITHOUT SIGNATURE)

NOTICE TO REFERRING PROVIDER: Please complete and sign this form and give to patient. All studies require a physician order in addition to this form.

NOTICE TO PATIENT: Your physician has approved your visit to a contracted Radiology provider. Please call the phone number provided by your physician to make an appointment and BRING THIS FORM & PHYSICIAN ORDER FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO RADIOLOGY CENTER: **No Prior Authorization required.**

REFERRING PROVIDER MUST BE LISTED ON BOX 17 OF CMS 1500.

Plain X-RAY Films and UGI		Ultrasound, Dexa, Doppler
☐ Chest	☐ Hip	☐ DXA Scan
☐ Knee	☐ Ankle	☐ Doppler
☐ Forearm	☐ Foot	☐ Ultrasound: location_____
☐ Hand	☐ Wrist	
☐ Lumbar Spine	☐ Plain Abdominal	
☐ Plain Sinus–3 views	☐ UGI	
☐ Other Skeletal Films: _____		

Mammography	Studies that REQUIRE Prior Authorization
☐ 77067– SCREENING, BILATERAL	CT/CTA, MRI/MRA, PET, IR, Diagnostic Vascular Radiology and OTHER DIAGNOSTIC RADIOLOGY
☐ 77066– DIAGNOSTIC, BILATERAL	
☐ 77065– DIAGNOSTIC, UNILATERAL	
☐ 77063 – SCREENING BREAST TOMOSYNTHESIS, BILATERAL	

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