VIP
Diagnostic Imaging

DATE:_____

PATIENT NAME: _____, _____, _____ DOB: _____
(last) (first) (M.I.)

Address_____ City_____ State____ Zip_____

Home Phone # (_____)-_____-_____Work Phone # (_____)-_____-_____ext.# _____

Referred By:_____ M.D. Dx/Reason for visit_____

Primary Insurance Company_____

Group #_____ Policy#_____ Telephone #_____

Insured's Name_____ Relationship to Patient_____

Employer_____

Secondary Insurance Company_____

Group#_____Policy#_____

---------- **FOR OFFICE USE ONLY** ----------

RAMG	OMNIRAD	PREMIER
Tax ID 94-1726382	Tax ID: 27-2116790	Tax ID: 46-1653626

PROCEDURE	CODE	GLOBAL FEE
Sinus, Facial, TMJ-CT Maxillofacial w/o cont	70486	
Temporal Bone CT-Orbit, sella Posterior fossa, or outer, middle, Inner ear-w/o cont	70480	

Diagnosis Code:_____ **To Med Tech _____**
(Initials)

Pre Cert #:_ _____ **To Billing Folder _____**
(Date)