RHODE ISLAND **MEDICAL IMAGING**

Scheduling: 401-432-2400 • Fax: 401-432-2519 • www.rimirad.com

Patient Name: _____ DOB: _____ Phone Number: _____

Insurance Coverage: _____ Authorization: _____

Clinical Decision Support G Code: _____ Clinical Decision Support Modifier: _____

Symptoms / Reason for Exam: _____

(Include as many signs and symptoms as applicable – "r/o or question of" is not sufficient)

CT Dentascan

- ❒ Maxilla (Upper)
- ❒ Mandible (Lower)

❒ CD (Via Mail)

❒ Paper Print (Via Mail)

Special Instructions:

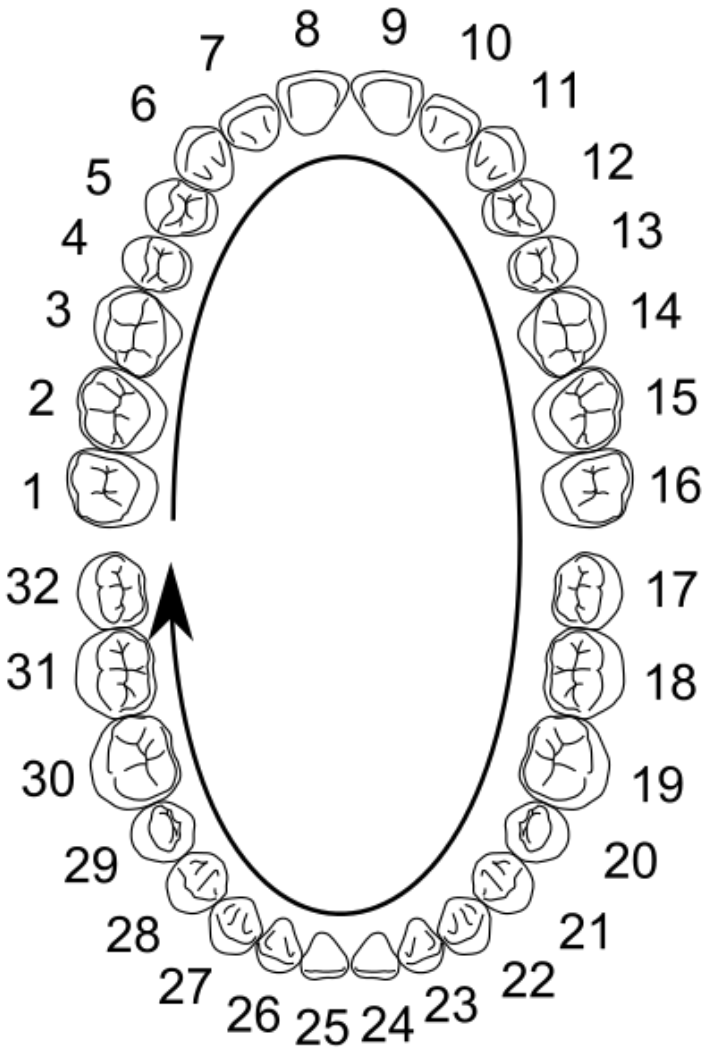
_____

_____

_____

_____

_____



Referring Physician's Name _____ NPI Number _____

Signature _____

Date _____ RIMI Location Preferred _____