

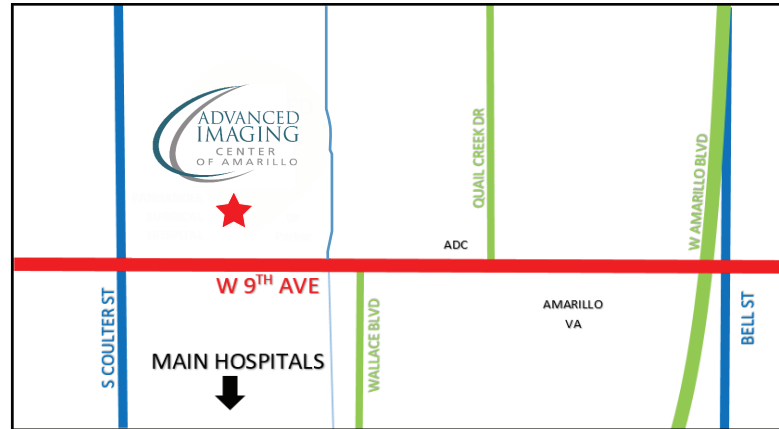
CT SCANS	ICD10	CPT
<input type="checkbox"/> Head WO Contrast		70450
<input type="checkbox"/> IACS WO Contrast		70480
<input type="checkbox"/> Sinus/Facial Bones WO Contrast		70486
<input type="checkbox"/> CTA Head W WO Contrast		70496
<input type="checkbox"/> CTA Neck W Contrast		70498
<input type="checkbox"/> Chest WO Contrast		71250
<input type="checkbox"/> W High Resolution		
<input type="checkbox"/> Chest W Contrast		71260
<input type="checkbox"/> CTA Chest W Contrast		71275
<input type="checkbox"/> CTA Pulmonary Angiogram (PE) W Contrast		71275
<input type="checkbox"/> Cervical Spine WO Contrast		73201
<input type="checkbox"/> Thoracic Spine WO Contrast		72128
<input type="checkbox"/> Lumbar Spine WO Contrast		72131
<input type="checkbox"/> Enterography		74177
<input type="checkbox"/> CTA Chest Abdomen Pelvis W Contrast		71275
		74174
<input type="checkbox"/> W Long Leg Runoff		75635
<input type="checkbox"/> CTA Abdomen Pelvis W Contrast		74174
<input type="checkbox"/> W Long Leg Runoff		75635
<input type="checkbox"/> Hip WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Femur WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Knee WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Tibia Fibula WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Ankle WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Foot WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73700
<input type="checkbox"/> Shoulder WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
<input type="checkbox"/> Humerus WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
<input type="checkbox"/> Elbow WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
<input type="checkbox"/> Forearm WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
<input type="checkbox"/> Wrist WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
<input type="checkbox"/> Hand WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73200
PROTOCOL: _____		
<input type="checkbox"/> Other _____		



A DEPARTMENT OF
PHYSICIANS SURGICAL
HOSPITALS, L.L.C.



SEND PATIENT TO:
7010 W. 9TH AVE.
AMARILLO, TX 79106
PH 806-351-8480
FAX 806-500-2938 OR
806-351-8489
AIC.Scheduling@bsahs.org



Patient Name: _____
DOB: _____ Pregnant: Yes / No
Appointment Date and Time: _____
OR AIC to call patient to schedule: Yes / No
AIC to get Auth: Yes / No
If Yes, please attach clinicals and demographics.
If No, Pre-Authorization Number: _____

MRI Screening Questions:
Does the patient have (circle one): Stents / Pacemaker
Neurostimulator / Other Implants / No Implants
Is the patient Claustrophobic? Yes / No
Weight: _____

ARTHROGRAMS	ICD10	CPT
<input type="checkbox"/> MR Shoulder Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 23350, 73222
<input type="checkbox"/> MR Hip Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 27093, 73722
<input type="checkbox"/> MR Knee Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 27369, 73722
<input type="checkbox"/> CT Shoulder Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 23350, 73201
<input type="checkbox"/> CT Hip Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 27093, 73701
<input type="checkbox"/> CT Knee Arthrogram <input type="checkbox"/> Left <input type="checkbox"/> Right		77012, 27369, 73701

MRI	ICD10	CPT
<input type="checkbox"/> MR Angiogram Head/Brain WO Contrast		70544
<input type="checkbox"/> MR Venogram Head/Brain WO Contrast		70544
<input type="checkbox"/> Brain WO Contrast		70551
<input type="checkbox"/> Brain W WO Contrast		70553
<input type="checkbox"/> Brain and Orbits W WO Contrast		70543
		70553
<input type="checkbox"/> Brain and Pituitary W WO Contrast		70553
<input type="checkbox"/> Brain and IAC W WO Contrast		70553
<input type="checkbox"/> IAC W WO Contrast		70553
<input type="checkbox"/> MR Angiogram Neck WO Contrast		70547
<input type="checkbox"/> Neck Soft Tissue Only W WO Contrast		70543
<input type="checkbox"/> Chest WO Contrast		71550
<input type="checkbox"/> Chest W WO Contrast		71552
<input type="checkbox"/> Cervical Spine WO Contrast		72141
<input type="checkbox"/> Cervical Spine W WO Contrast		72156
<input type="checkbox"/> Thoracic Spine WO Contrast		72146
<input type="checkbox"/> Thoracic Spine W WO Contrast		72157
<input type="checkbox"/> Lumbar Spine WO Contrast		72148
<input type="checkbox"/> Lumbar Spine W WO Contrast		72158
<input type="checkbox"/> Abdomen WO Contrast		74181
Area of Interest _____		
<input type="checkbox"/> MRCP WO Contrast		74181
<input type="checkbox"/> Abdomen W WO Contrast		74183
Area of Interest _____		
<input type="checkbox"/> Liver W WO Contrast		74183
<input type="checkbox"/> Pelvis WO Contrast		72195
<input type="checkbox"/> Pelvis W WO Contrast		72197
<input type="checkbox"/> Sacrum and SI Joint WO Contrast		72195
<input type="checkbox"/> Hip WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73721
<input type="checkbox"/> Femur WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73718
<input type="checkbox"/> Knee WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73721
<input type="checkbox"/> Knee W WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73723
<input type="checkbox"/> Tibia Fibula WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73718
<input type="checkbox"/> Ankle WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73721
<input type="checkbox"/> Hindfoot WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73718
<input type="checkbox"/> Forefoot WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73718
<input type="checkbox"/> Brachial Plexus WO Contrast		73218
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Shoulder WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73221
<input type="checkbox"/> Humerus WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73218
<input type="checkbox"/> Elbow WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73221
<input type="checkbox"/> Radius Ulna WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73218
<input type="checkbox"/> Wrist WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73221
<input type="checkbox"/> Hand WO Contrast <input type="checkbox"/> Left <input type="checkbox"/> Right		73218
<input type="checkbox"/> Other _____		

AUTHORIZE FOR:
PHYSICIANS SURGICAL HOSPITALS, L.L.C
6819 PLUM CREEK DR.
AMARILLO, TX 79124
TID 73-1620274 NPI 1912948845

STAT READ: Yes/No Decision Support – Vender: _____ Session ID: _____ Score: _____
Physician Name: _____ Physician Signature: _____ Date: _____

SEND PATIENT TO:
 7010 W. 9TH AVE.
 AMARILLO, TX 79106
 PH 806-351-8480
 FAX 806-500-2938 OR
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Ultrasound	ICD10	CPT
OB		
<input type="checkbox"/> < 14 Weeks Single Gestation		76801
<input type="checkbox"/> Each Additional Gestation		+76802
<input type="checkbox"/> 14+ Weeks Single Gestation		76805
<input type="checkbox"/> Each Additional Gestation		+76810
<input type="checkbox"/> Detail Fetal Anatomy Single Gestation		76811
<input type="checkbox"/> Each Additional Gestation		+76812
<input type="checkbox"/> Limited		76815
<input type="checkbox"/> Follow-Up Transabdominal Approach		76816
<input type="checkbox"/> Transvaginal		76817
<input type="checkbox"/> Fetal Biophysical Profile with Non Stress Testing		76818
<input type="checkbox"/> Without Non Stress Testing		76819
<input type="checkbox"/> Other _____		
NON-OB		
<input type="checkbox"/> Thyroid		76536
<input type="checkbox"/> Breast Complete <input type="checkbox"/> Left <input type="checkbox"/> Right		76641
<input type="checkbox"/> Breast Soft Tissue Limited <input type="checkbox"/> Left <input type="checkbox"/> Right		76642
<input type="checkbox"/> Abdomen Complete		76700
<input type="checkbox"/> Abdomen Limited – Specify Organ _____		76705
<input type="checkbox"/> Soft Tissue Abdomen – Specify Site _____		76705
<input type="checkbox"/> Renal Complete		76770
<input type="checkbox"/> Renal Limited		76775
<input type="checkbox"/> Non-OB Transvaginal		76830
<input type="checkbox"/> Pelvis Transabdominal Complete		76856
<input type="checkbox"/> Urinary Bladder Limited		76857
<input type="checkbox"/> Pelvic Bladder Only		76857
<input type="checkbox"/> Pelvis Limited		76857
<input type="checkbox"/> Soft Tissue Penis		76857
<input type="checkbox"/> Groin		76857
<input type="checkbox"/> Scrotum and Testicles Without Duplex		76870
<input type="checkbox"/> With Duplex		+93976
<input type="checkbox"/> Upper Extremity Non Vascular Complete		76881
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Upper Extremity Non Vascular Limited		76882
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Soft Tissue Upper Extremity		76882
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Lower Extremity Non Vascular Complete		76881
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Lower Extremity Non Vascular Limited		76882
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Soft Tissue Lower Extremity		76882
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Other _____		

Patient Name: _____
 DOB: _____ Pregnant: Yes / No
 Appointment Date and Time: _____
 OR AIC to call patient to schedule: Yes / No
 AIC to get Auth: Yes / No
 If Yes, please attach clinicals and demographics.
 If No, Pre-Authorization Number: _____

Vascular Doppler	ICD10	CPT
<input type="checkbox"/> Carotid Bilateral		93880
<input type="checkbox"/> Left <input type="checkbox"/> Right		93882
<input type="checkbox"/> Abdominal Aorta Complete		93978
<input type="checkbox"/> IVC		93978
<input type="checkbox"/> Renal Complete <input type="checkbox"/> Artery <input type="checkbox"/> Vein		93976
<input type="checkbox"/> Renal Limited <input type="checkbox"/> Artery <input type="checkbox"/> Vein		93975
<input type="checkbox"/> Renal Artery Duplex Limited		93978
<input type="checkbox"/> Arterial Legs Bilateral		93925
<input type="checkbox"/> Left <input type="checkbox"/> Right		93926
<input type="checkbox"/> Venous Legs Bilateral <input type="checkbox"/> With Reflux		93970
<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> With Reflux		93971
<input type="checkbox"/> Arterial Arms Bilateral		93930
<input type="checkbox"/> Left <input type="checkbox"/> Right		93931
<input type="checkbox"/> Venous Arms Bilateral		93970
<input type="checkbox"/> Left <input type="checkbox"/> Right		93971
<input type="checkbox"/> Other _____		

STAT READ: Yes/No _____ Date: _____
 Decision Support – Vender: _____
 Session ID: _____ Score: _____
 Physician Name: _____
 Physician Signature: _____

XRAYS	ICD10	CPT
<input type="checkbox"/> Facial Bones 3+ VW Bilat		70150
<input type="checkbox"/> Sinuses <3 VW		70210
<input type="checkbox"/> Sinuses 3+ VW		70220
<input type="checkbox"/> Skull <4 VW		70250
<input type="checkbox"/> Chest 1 VW		71045
<input type="checkbox"/> Chest 2 VW		71046
<input type="checkbox"/> Ribs 2 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		71100
<input type="checkbox"/> Cervical Spine <input type="checkbox"/> 2 VW <input type="checkbox"/> 3 VW		72040
<input type="checkbox"/> 4 VW <input type="checkbox"/> Complete 5 VW		72050
<input type="checkbox"/> Complete 6+ VW		72052
<input type="checkbox"/> Thoracic Spine 2 VW		72070
<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> 2 VW <input type="checkbox"/> 3 VW		72100
<input type="checkbox"/> AP Lateral with Flexion Extension		72110
<input type="checkbox"/> Complete with Bending		72114
<input type="checkbox"/> Pelvis <input type="checkbox"/> 1 VW <input type="checkbox"/> 2 VW		72170
<input type="checkbox"/> Sacrum and Coccyx		72200
<input type="checkbox"/> Sacroiliac Joints 3+ VW		72202
<input type="checkbox"/> Abdomen 1 VW		74018
<input type="checkbox"/> Abdomen 2 VW AP with Upright		74019
<input type="checkbox"/> Hip 2+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73502
<input type="checkbox"/> Femur 2 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73552
<input type="checkbox"/> Knee 2 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73560
<input type="checkbox"/> Knee/Patella 3 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73562
<input type="checkbox"/> Knee 4+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73564
<input type="checkbox"/> Tibia Fibula 2 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73590
<input type="checkbox"/> Ankle 3+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73610
<input type="checkbox"/> Calcaneus 2+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73650
<input type="checkbox"/> Foot 3+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73630
<input type="checkbox"/> Toe 2+ VW Digit _____ <input type="checkbox"/> Left <input type="checkbox"/> Right		73660
<input type="checkbox"/> Scapula <input type="checkbox"/> Left <input type="checkbox"/> Right		73010
<input type="checkbox"/> Shoulder 1 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73020
<input type="checkbox"/> Shoulder 2+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73030
<input type="checkbox"/> Shoulder Complete 2+ VW (Includes Y View)		73030
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Acromioclavicular Joints Bilateral W WO Weights		73050
<input type="checkbox"/> Humerus <input type="checkbox"/> Left <input type="checkbox"/> Right		73060
<input type="checkbox"/> Elbow 2 VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73070
<input type="checkbox"/> Elbow 3+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73080
<input type="checkbox"/> Forearm <input type="checkbox"/> 2 VW <input type="checkbox"/> 3 VW		73090
<input type="checkbox"/> Left <input type="checkbox"/> Right		
<input type="checkbox"/> Wrist 3+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73110
<input type="checkbox"/> Hand 3+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73130
<input type="checkbox"/> Finger 2+ VW Digit _____ <input type="checkbox"/> Left <input type="checkbox"/> Right		73140
<input type="checkbox"/> Thumb 2+ VW <input type="checkbox"/> Left <input type="checkbox"/> Right		73140
<input type="checkbox"/> Bone Age		77072
<input type="checkbox"/> Other _____		