



**CRMC OUTPATIENT
IMAGING/LAB**
190 D Westside Drive
Douglas, GA 31533
Ph: 912-384-1900
Scheduling- Ext 4153
Information- Ext 4354
Fax: 912-383-5675



Ins / Precert Info:

Patient Name: _____ DOB: _____

Diagnosis: _____

Insurance Co. Name: _____

Insurance Rep. Name: _____

Ins. Phone # _____

Policy Number: _____

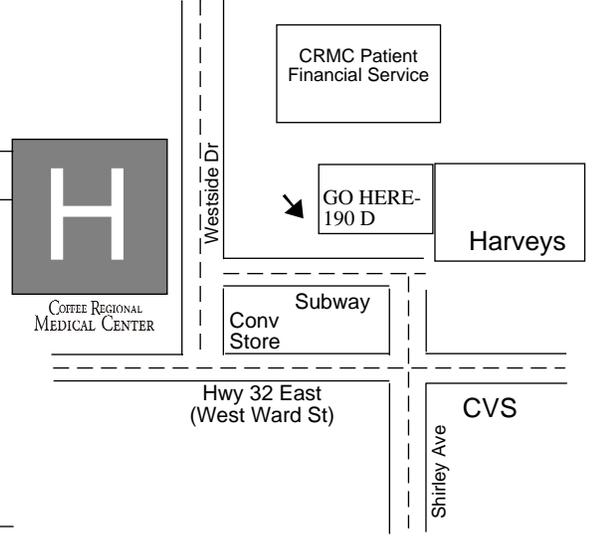
Insured Name: _____

Precert Number: _____

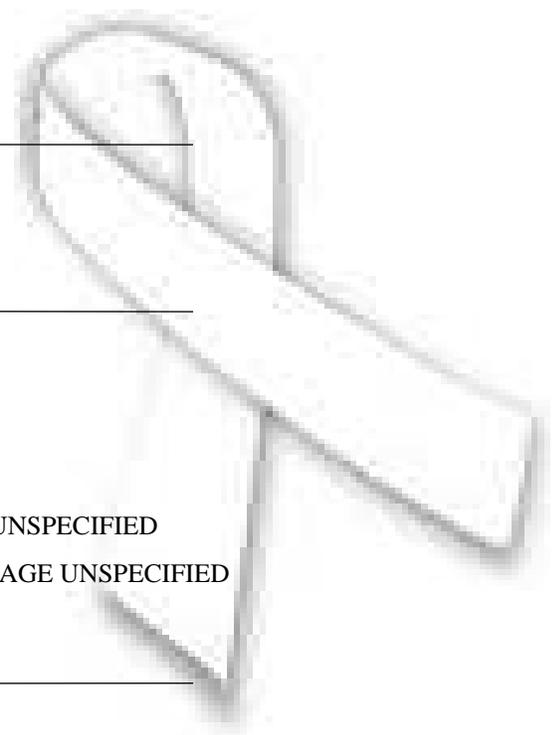
Date Written: _____ Time: _____

Date Scheduled: _____

Physician: (print) _____



- _____ **EMPLOYEE SCREENING (77067)**
- _____ **MAMMOGRAM SCREENING BILATERAL (Z12.31) (77067)**
- _____ **MAMMOGRAM SCREENING UNILATERAL LEFT/RIGHT (77067)**
- _____ **DIAGNOSTIC MAMMOGRAM BILATERAL (77066)**
- _____ **DIAGNOSTIC MAMMOGRAM UNILATERAL LEFT/RIGHT (77065)**
 - _____ R92.8 ABNORMAL MAMMOGRAM
 - _____ N63 LUMP / MASS
 - _____ N64.4 BREAST PAIN
 - OTHER _____
- _____ **STEREOTACTIC BREAST BIOPSY (CPT 77031)**
 - PATIENT'S WEIGHT** _____
 - _____ R92.8 ABNORMAL MAMMOGRAM
 - OTHER _____
- _____ **(NO ASPIRIN OR ASPIRIN PRODUCTS X 3 - 5 DAYS)**
- _____ **BONE DENSITY (DEXA) (CPT 77080)**
 - PATIENT'S WEIGHT** _____
 - _____ M81.0 OSTEOPOROSIS
 - OSTEOPENIA _____ M89.9 DISORDER OF BONE, UNSPECIFIED
 - _____ M94.9 DISORDER OF CARTILAGE UNSPECIFIED
 - OTHER _____



_____ **PHYSICIAN SIGNATURE** **DATE** **TIME**