

SCHEDULINGP: 800.734.4132
F: 207.883.6348 Call patient to schedule**If faxing an order, please include:**

- Demographics
- Insurance card
- Clinical notes

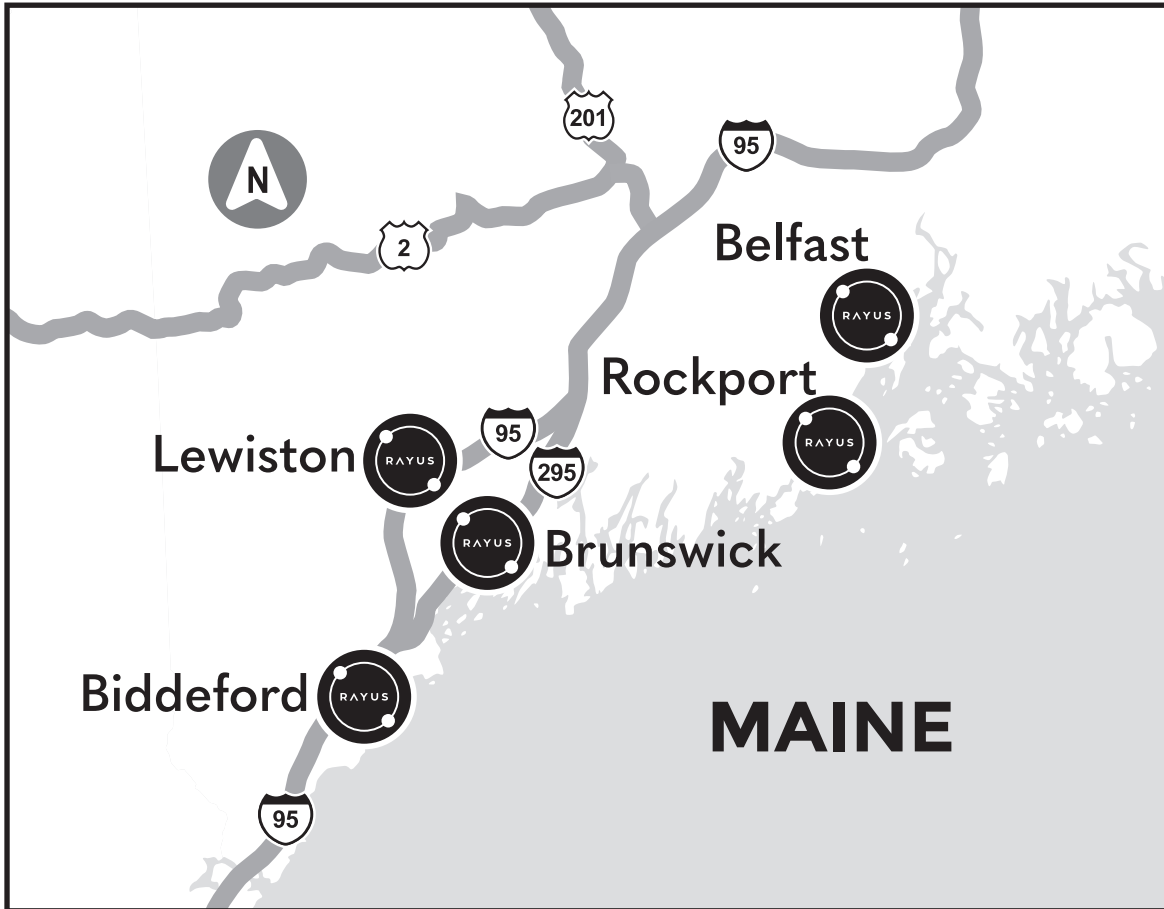

**Maine Molecular
Imaging**
 **RAYUS RADIOLOGY
MMI BELFAST**
118 Northport Ave.
Belfast, ME 04915
NPI: 1659329985
 **RAYUS RADIOLOGY
MMI BIDDEFORD**
1 Medical Center Dr.
Biddeford, ME 04005
NPI: 1548219579
 **RAYUS RADIOLOGY
MMI BRUNSWICK**
123 Medical Center Dr.
Brunswick, ME 04011
NPI: 1285682591
 **RAYUS RADIOLOGY
MMI LEWISTON**
93 Campus Ave.
Lewiston, ME 04240
NPI: 1972551299
 **RAYUS RADIOLOGY
MMI ROCKPORT**
6 Glen Cove Dr.
Rockport, ME 04856
NPI: 1184161085

Appointment date and time		Patient DOB		<input type="radio"/> M <input type="radio"/> F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #	
Insurance name		Insurance ID #	Authorization #	
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	Date of injury	Patient height	Patient weight	
(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include specific clinical indications (such as location, context and severity) to support medical necessity for each test.		Clinical Decision Support (CDS) Required for Medicare Part B		
		Modifier (determination)	G-code (vendor)	
Is the exam/procedure related to an injury? <input type="radio"/> No <input type="radio"/> Yes If yes <input type="radio"/> Initial <input type="radio"/> Subsequent or <input type="radio"/> Sequela				

PET/CT
Weight limit 450 lbs.
<input type="radio"/> Whole body <input type="radio"/> Standard body (eyes to thighs) <input type="radio"/> Neurology <input type="radio"/> Cardiac viability

- Nothing by mouth 4 hours prior for Whole body and Neurology exams. Instructions for Cardiac viability provided on screening.
- Patients must be 4 weeks S/P chemo or radiation therapy.
- Patients are required to bring outside films. Physician's offices are required to fax the appropriate surgical, pathology and diagnostic reports. Please fax a copy of patient's insurance card.

PREVIOUS TREATMENTS/IMAGING/EXAMS <input type="radio"/> No <input type="radio"/> Yes What type _____			
REPORTING METHOD <input type="radio"/> STAT/ASAP <input type="radio"/> STAT: Call report _____			
Provider name (print)	Provider location City/Zip	Phone #	Fax #
Provider signature (required) Do not use rubber stamp.	NPI # (required for new providers)	Date	



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