X-RAY ORDER FORM

O Patient will call to schedule
O Call patient to schedule

RAYUS RADIOLOGY™

O DEDHAM
200 Providence Hwy., Suite 210
Dedham, MA 02026
P: 781.329.0600
F: 781.329.1713
E: BostonOrders@RAYUSradiology.com

O SPRINGFIELD
3640 Main St., Suite 101
Springfield, MA 01107
P: 413.781.9000
F: 413.781.7988
E: SpringfieldOrders@RAYUSradiology.com

Appointment date and time	Check-in time	Patient DOB

Patient name (as shown on insurance card)	O M O F

Primary phone #	Secondary phone #

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.

Is the exam/procedure related to an injury? O No O Yes **If yes** O Initial O Subsequent or O Sequela

X-RAY

O Chest (standing PA)

Provider name (print)	

Provider location City/Zip	Phone #

Provider signature (required)
Do not use rubber stamp.

NPI # (required for new providers)	Date