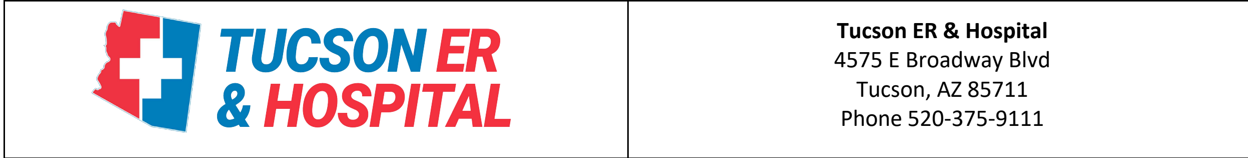
Request for Outpatient Services



Tucson ER & Hospital
4575 E Broadway Blvd
Tucson, AZ 85711
Phone 520-375-9111

Patient Information

____

Last Name **First Name** **Middle Name**

____

Date of Birth **Primary Phone Number**

Name of Insurance Provider/ Policy # ____

Pre-Certification: ◯ **Not Required** ◯ **In Progress** ◯ **Completed**

Pre-Cert/Authorization# ______________________

Reason for Test

REASON FOR THE TEST MUST BE GIVEN.

• ICD codes AND diagnostic information must be provided for EACH test ordered.

• **Please DO NOT USE "Rule Out" or "Possible/Probable?"**

____

Outpatient Testing or Procedure Order

____

Reason/Diagnosis

____

ICD Code(s)

Order/ Results

Requested Test Date:

◯ ROUTINE at patient's convenience ◯ URGENT w/in 48 hours ◯ STAT

Date: ________________________

• Orders are valid for 90 days.

Results: ◯ Fax results ___________________ ◯ Call results __________________

◯ Hold patient for results send images with patient

Physician Information

____

Referring Practitioner: Last Name First Name NPI #

____

Practitioner's Phone Number Practitioner's Fax Number

____

Practitioner's Signature Date

Notice: Tucson ER & Hospital is unable to bill Medicare, Medicaid for services rendered.

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