ZoomCare Imaging Provider Referral Form

zoomcare®

Please send completed form to ZoomCare:
Fax: 866-859-8195
Email: imagescheduling@zoomcare.com

Today's date:____________________

PATIENT INFORMATION

Name: ____________________________ DOB :____________ Phone: ____________________________

Email: ____

Reason for exam: ______________________________________ ICD10 code: _______________________

Insurance company: __________________________ Insurance ID # ______________________________

Insurance pre-authorization # and date range: ____

ORDERING PROVIDER INFORMATION

Ordering provider name: ____________________________Signature: ______________________________

NPI:_______________________ License #: _______________________ Tax ID:____________________

Date: _____________ Phone: _________________________ Fax:_________________________________

Facility/clinic name: ____

Address: ___________________________ City: ___________________ State: _____ Zip Code: _______

- ❏ Fax report only
- ❏ Fax report & mail imaging CD to: ____

EXAMINATION INFORMATION

ZoomCare performs X-Ray, CT (with or without contrast) and Ultrasound

Study name(s) ____ CT ▢ X-Ray ▢ Ultrasound ▢

For X-Ray: Number of views _______ Laterality: Left ▢ Right ▢ Bilateral ▢

For CT: Contrast ▢ No contrast ▢

For Ultrasound: Transvaginal ▢ Transabdominal ▢

Additional studies (if needed): ____

COMMENTS: ____

Call our Help Team at 503-684-8252 for support.

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