TridentCare AT HOME℠

Exam Request Form

for Ordering Providers

Thank you for choosing TridentCare At Home!

To order portable imaging services, please complete the attached "Exam Request Form" in its entirety to help expedite your request for services.

IMPORTANT NOTE: If this Exam Request Form is not signed by the ordering physician/nonphysician practitioner, please include the signed order with the completed Exam Request Form.

Federal Regulations at 42 CFR §486.106 and §410.32 at a Glance

42 CFR §486.106 and §410.32 require portable x-ray suppliers, like TridentCare At Home, to obtain specific information at the time of a referral for portable x-ray services to ensure that the physician or nonphysician practitioner's order, as documented in the patient's medical record, complies with these regulations. Specifically, these regulations require that the physician or nonphysician practitioner who orders the service maintain documentation of medical necessity in the beneficiary's medical record. Additionally, the signed documentation of a written, electronic, or telephonic order should include the following data elements:

- Reason the x-ray exam is required
- Area of the body to be exposed
- Number of views needed
- A statement concerning the condition of the patient which indicates why portable x-ray services are necessary

To Place An Order or Speak to a Client Service Representative About An Order:

States	Call Center Phone	Call Center Fax #
CT, MA, ME, NH, RI, VT	800-442-9729	866-250-2872
IL, IN, KY, MI, OH, WV, WI	800-932-2222	866-250-2872
DE, MD, NJ, PA, VA, Washington DC	800-821-9236	855-231-2887
AL, FL, GA, MS, NC, SC, TN	800-940-0389	877-469-1808
AZ, CA, KS, MO, NE, NV, TX	800-843-9729	855-232-0249
CO, NM, OR, WA	888-418-9555	855-232-0249

You may also place orders online at www.tridentconnect.com.

For any additional information or questions, please send email to: Info.AtHome@tridentcare.com.

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Date / Time Faxed: _____

Requested Date of Service: _____

Customer Name: _____

ID Number: _____

Phone Number: _____

Fax Number: _____

Contact Name / Title: _____

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

Male / Female: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Patient's Phone Number: _____

Alternate Phone Number: _____

SNF / ALF / ILF / Apt / Mobile Home / Private Home (Circle One)

How Many Stairs Required for Entering the Home? _____

Special Instructions: _____

_____

Medicare Number: _____
Medicaid Number: _____
HMO/Other Insurance: _____
Policy Number: _____
Group Number: _____
Authorization Number: _____

Is This Exam Hospice Related? YES / NO (Circle One) If Yes:
Hospice Agency/Payer:_____
Hospice Agency NPI:_____
Medicare MBI #:: _____

Exam Requested: _____ Symptoms / Reason for Exam:_____

Number of Views (X-ray Only): _____ ***Notice! If left blank, the minimum number of views will be ordered.***

Statement Concerning the Condition of the Patient Requiring Portable Services: _____

_____

Physician / Practitioner's Name: _____

Physician / Practitioner's NPI Number: _____

Physician / Practitioner's Phone Number: _____

Physician / Practitioner's Fax Number: _____

Statement concerning the condition of the patient requiring portable services:

The exam(s) that I ordered for this patient were medically indicated and necessary for the above named patient's treatment and/or diagnosis. The results of the exam(s) have or will be used in the treatment of the patient's medical condition. For the reason(s) indicated above, the patient would find it physically and/or psychologically taxing to receive the exam(s) in a place other than the patient's home/residence.

Medical record attestation statement:

I hereby attest that the medical record entry for the date of service, noted above, accurately reflects the signatures and notations that I made in my capacity as ordering physician or nonphysician practitioner when I treated this patient. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of a material fact related to the treatment of this patient may subject me to administrative, civil, or criminal liability.

Physician / Practitioner Signature: _____ Date: _____

I certify that the order and medical necessity for the exam ordered above is documented in the patient's medical chart/record.

Nurse Signature: _____ Date: _____

If this Exam Request Form is not signed by the ordering physician/nonphysician practitioner, please include the signed order.