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 Regulation at 42 CFR §486.106 at a Glance**

42 CFR §486.106 requires portable x-ray suppliers, like TridentCare At Home, to obtain specific information at the time of an order 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 42 CFR §486.106 and related regulations. Specifically, this regulation requires written, signed documentation of a written, electronic, or telephonic order. The order should include:

- 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:**

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

You may also place orders online at [www.tridentconnect.com](http://www.tridentconnect.com).

For any additional information or questions, please send email to: [Info.AtHome@tridentcare.com](mailto:Info.AtHome@tridentcare.com).

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

3/2020
Exam Request Form for Ordering Providers

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: ____________________________  Is This Exam Hospice Related? YES / NO (Circle One)  If Yes:

Medicaid Number: ____________________________  Hospice Carrier: ____________________________

HMO/Other Insurance: ____________________________  Hospice Policy Number: ____________________________

Policy Number: ____________________________  Hospice Effective Date: ____________________________

Group Number: ____________________________  Date Policy Expires: ____________________________

Authorization Number: ____________________________

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. 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 Medicare beneficiary. 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: ____________________________