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.

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**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:**

<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.

03.23.2021
### Exam Request Form

**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:** _____________________________

---

**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:** _____________________________

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**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.

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**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:** _____________________________

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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:** _____________________________

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

03.23.2021