St. Vincent IPA
The Patient's Choice for Health Care

LA AREA DIRECT REFERRAL REQUISITION FORM

Date of Referral Request: _____/_____/_____

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Patient Name (First, MI, Last): _____

Address: _____ **City:** _____ **State:** _____ Zip: _____

Date of Birth: _____/_____/_____ **Phone:** ( ) _____ **Patient ID #:** _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: ( ) _____ Referring Physician Fax: ( ) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

☐ **UMI of Los Angeles**
1127 Wilshire Blvd.
#100
Los Angeles, CA 90017
Tel: 213-223-5000

☐ **Radnet Beverly Towers Women's Center**
465 Roxbury Dr.
Suite 101
Beverly Hills, CA 90210
Tel: 310-385-7747

☐ **Beverly Tower Wilshire Advanced Imaging**
8750 Wilshire Blvd,
Suite 100
Beverly Hills, CA 90211
Tel: 310-689-3100

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM****

HEAD & NECK
- ☐ 70250 - Skull <4V
- ☐ 70486-CT Sinus Survey

CHEST
- ☐ 71045 –1V
- ☐ 71046 –2V
- ☐ 71100 - Ribs Uni 2V
- ☐ 71120 - Sternum Min 2V

SPINE & PELVIS
- ☐ 72040-Spine Cervical 2 or 3V
- ☐ 72070-Spine Thoracic 2V
- ☐ 72100-Spine Lumbosacral 2-3V
- ☐ 72170 -Pelvis 1V
- ☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
- ☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
- ☐ 73030 - Shoulder min 2V
- ☐ 73070 - Elbow 2V
- ☐ 73090 - Forearm 2V
- ☐ 73100 - Wrist 2V
- ☐ 73120 - Hand 2V
- ☐ 73140 - Fingers min 2V

ABDOMEN
- ☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
- ☐ 73502 - Hip unilateral min 2V
- ☐ 73521 - Hip bilateral min 2V
- ☐ 73552 – Femur 2V
- ☐ 73560 - Knee 1 or 2V
- ☐ 73590 - Tibia & Fibula 2V
- ☐ 73600 - Ankle 2V
- ☐ 73620 - Foot 2V
- ☐ 73650 - Calcaneus min 2V
- ☐ 73660 - Toes min 2V

LA AREA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &√ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☜ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:

☐ 99203 –OB/GYN Consult (Annual) – Age >65

☐ 99213 - OB/GYN Follow-up

☐ 99395 - Well Women Exam (Annual) – Age 18-39

☐ 99396 - Well Women Exam (Annual) – Age 40-64

☐ 99397 - Well Women Exam

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 02.22.2021