

Request for Outpatient Services



West Plano Emergency Room
2000 Dallas Pkwy #100
Plano, TX 75093
Phone 972-378-7878 Fax 469-543-0666

Patient Information

Last Name	First Name	Middle Name	
Date of Birth	Primary Phone Number		
Name of Insurance Provider/ Policy # _____			
Pre-Certification:	<input type="radio"/> Not Required	<input type="radio"/> In Progress	<input type="radio"/> Completed
Pre-Cert/Authorization# _____			

Reason for Test

REASON FOR THE TEST MUST BE GIVEN.

- ICD codes AND diagnostic information must be provided for EACH test ordered.
- Please DO NOT USE "Rule Out" or "Possible/Probable?"

Outpatient Testing or Procedure Order

Reason/Diagnosis

ICD Code(s)

Order/ Results

Requested Test Date:

- ROUTINE at patient's convenience URGENT w/in 48 hours STAT

Date: _____

- Orders are valid for 90 days.

Results: Fax results _____ Call results _____
 Hold patient for results send images with patient

Physician Information

Referring Practitioner:	Last Name	First Name	NPI #
Practitioner's Phone Number	Practitioner's Fax Number		

Practitioner's Signature _____ Date _____

Notice: West Plano Emergency Room is unable to bill Medicare, Medicaid or Tricare for services rendered.

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