

This form is part of the patient's medical record and must be completed for referral

Patient Name _____
(First) (MI) (Last)
 Home Number (____) _____ - _____ Work (____) _____ - _____
 Date of Birth _____ - _____ - _____ Social Security Number _____ - _____ - _____
 Insurance Provider _____
Please fax medical insurance information with referral

For scheduling:
 patient will call
 please call patient

Written Diagnosis/Reason/Symptoms for Exam(s) Required

Medicare and other insurers require coding of specific/definitive diagnosis(es), sign(s) or symptom(s) to reflect the "medical necessity" for each test.
Rule out, Possible or Probable Conditions cannot be coded. For Medicare Policy information see the Part B Bulletin or www.noridian.com/medweb

Examination

CT- Computed Tomography

- TMJs Mandible Mandible and Maxilla
- Sinus Maxilla Other _____
- Facial Bones

MRI-Magnetic Resonance Imaging

- TMJs

SimPlant Dental CT

- Maxilla Maxilla & Mandible Single Tooth _____
- Mandible Quadrant _____

Will a radiographic template be provided? Yes No
(If yes, patient will not be scanned unless they have it with them at time of service.)

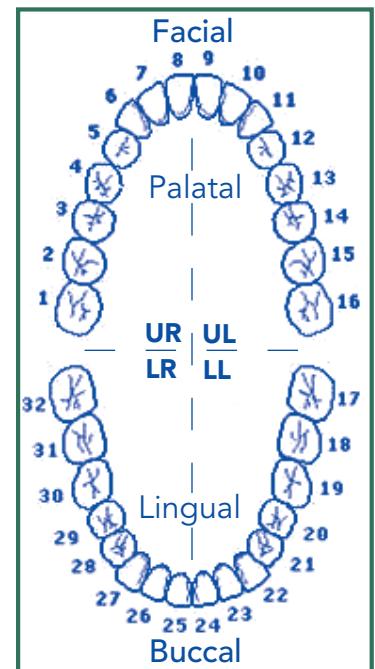
Please send SimPlant® Images in this format:

- Pro (Dentist has software)
- View (Free version of limited use software)
- One Shot (Pay per case software, \$200 charged at time of service)

X _____
Referring Provider Signature (Required for Exam)

Referring Provider Name _____
 Next Appointment with Patient _____
 Send Images to _____
 Address _____

Phone Number (____) _____ - _____
 Fax Number (____) _____ - _____
 Phone Number (____) _____ - _____
 Fax Number (____) _____ - _____



Please indicate area of concern or anticipated implant.

Note: To ensure correct and appropriate patient care and comply with federal rules and regulations, TRA Medical Imaging's policy is to require a written referral from the treating physician. The referral (order) must include both a diagnosis (narrative or ICD-9 code), signs or symptoms pertinent to the exam requested. For more information, please call (253) 761-4200.

EXCELLENCE • PERSON TO PERSON

Scheduling
Scheduling Fax

(253) 761-4200
(253) 761-4201

Toll-Free
Fax

(866) 761-4200
(866) 761-4201



TRA-Tacoma

Dental CT and SimPlant™

2202 S Cedar St, Ste 200

Tacoma WA 98405

(253) 761-4200 scheduling & clinic

(253) 761-4201 fax

(253) 284-0622 medical records fax



TRA-On Union

MRI of TMJ only

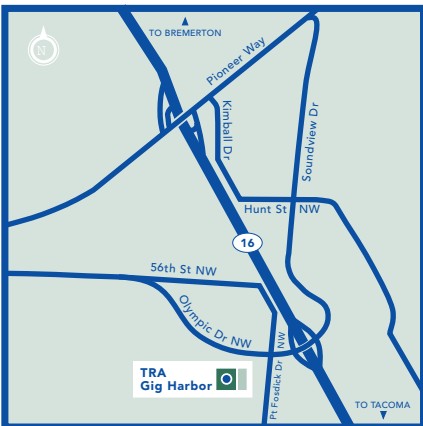
2502 S Union Ave

Tacoma WA 98405

(253) 759-5900 scheduling

(253) 759-6188 clinic

(253) 759-6252 fax



TRA-Gig Harbor

Dental CT and SimPlant™

4700 Point Fosdick Drive NW, Ste 110

Gig Harbor WA 98335

(253) 761-4200 scheduling

(253) 851-1700 clinic

(253) 858-3013 fax



TRA-Lakewood

Dental CT and SimPlant™

5919 100th St SW

Lakewood WA 98499

(253) 761-4200 scheduling

(253) 588-7050 clinic

(253) 588-3870 fax