AUTHORIZATION FOR TUBERCULOSIS CHEST X-RAY

Facilities below have agreed to the reimbursement rate noted as payment in full

Name of Patient: ___________________________________ **Date of Birth:** ____/____/________

____ is authorized to **TAKE** **&** **READ** one PA chest x-ray.
(Physician, Clinic, or Hospital) (at reimbursement rate of $55.00, as full payment)

AUTHORIZATION GIVEN BY: _________________________ (Local Public Health Authority Representative)

OF _________________________ LOCAL HEALTH DEPARTMENT on ____/____/________ (Date)

SPECIAL REQUEST FOR ADDITIONAL VIEW:

Special Authorization for additional chest x-ray view was received

from:____
(Verbal Authorization by TB Program)

at the Oregon TB Program on ____/____/________ (Date)

by ____
(local public health authority representative)

Created 12/01/2009
Updated 6/23/2020