

**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** one PA chest x-ray.  
(Physician, Clinic, or Hospital) (at reimbursement rate of \$22.15, as full payment)

\_\_\_\_\_ is authorized to **READ** one PA chest x-ray.  
(Physician, Clinic, or Hospital) (at reimbursement rate of \$11.45, as full payment)

\_\_\_\_\_ is authorized to **TAKE & READ** one PA chest x-ray.  
(Physician, Clinic, or Hospital) (at reimbursement rate of \$33.60, as full payment)

**AUTHORIZATION GIVEN BY:** \_\_\_\_\_ (Local Health Dept. 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 Control Program)

at the Oregon TB Control Program on \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date)

by \_\_\_\_\_  
(local health department representative)