TUFTS Health Plan

# Bone Density Equipment Information Form

Certification by the International Society for Clinical Densitometry (ISCD) is required for Tufts Health Plan Providers wishing to perform and be reimbursed for bone density exams.

| **Physician Information** | | | |
|---|---|---|---|
| Physician name: | Provider ID: | | |
| Are you ISCD Certified? Yes ☐ No ☐ (Please attach copy of certificate) | Phone #: | | |
| Address: | City: | State: | Zip: |
| **Equipment Information** | | | |
| Manufacturer: | Model #: | Date of manufacture: | |

| **Modality** (check all that apply) | **Area(s) Examined** (check all that apply) |
|---|---|
| ☐ Dexa ☐ Axial | ☐ Spine ☐ Calcaneus |
| ☐ Sexa ☐ Peripheral | ☐ Hip ☐ Distal Femur |
| ☐ Ultrasound | ☐ Radius/Ulna |
| ☐ Cat Scan | ☐ Tibia |
| ☐ Other (specify) _____ | ☐ Other (specify) _____ |

I certify that any and all persons who will operate the bone density equipment have received appropriate training and that documentation of training will be kept on file. I certify that the information contained herein is true and complete to the best of my knowledge and belief.

Signature: _____

Title: _____ Date: _____

**Please mail or fax completed form to**:
Attn: Imaging Privileging Committee
Tufts Health Plan
1 Wellness Way
Canton, MA 02021-1166
Fax: 617.972.9556