

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 <input type="checkbox"/> No <input type="checkbox"/> (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)	
<input type="checkbox"/> Dexa <input type="checkbox"/> Axial <input type="checkbox"/> Sexa <input type="checkbox"/> Peripheral <input type="checkbox"/> Ultrasound <input type="checkbox"/> Cat Scan <input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Spine <input type="checkbox"/> Calcaneus <input type="checkbox"/> Hip <input type="checkbox"/> Distal Femur <input type="checkbox"/> Radius/Ulna <input type="checkbox"/> Tibia <input type="checkbox"/> Other (specify) _____	
<p>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.</p> <p>Signature: _____</p> <p>Title: _____ Date: _____</p> <p>Please mail or fax completed form to: Attn: Imaging Privileging Committee Tufts Health Plan 705 Mount Auburn Street, Mail Stop 84 Watertown, MA 02472-1508 Fax: 617.972.9556</p>			

[Provider Services](#)