Email Templates

Last Modified on 08/25/2025 4:23 pm EDT

Email Templates

Please use the following templates when emailing All_WR_CC_Leadership@washingtonradiology.com
Remember to always put **[ENCRYPT]** in the subject line of your emails that contain any patient information.

Provider/Medical Facility Requesting to Update or Change Information:

SUBJECT LINE: [ENCRYPT] REQUEST TO UPDATE PROVIDER INFORMATION

Name of Caller:
Title of Caller (Manager, Office Assistance, Nurse, PA, etc.):
Contact Number:
Name of Facility/Office Requiring Update:
Provider's Full Name:
Credentials (MD, DO, CNM, DDS, etc.):
NPI #:
Physician Specialty:

Physicians Current Information (what is to be removed or replaced):
Address (include street number, street name, suite, city, state & zip code):
Phone Number:
Fax Number:
Other Requests:

Physicians Updated/New Information (what is to be added):
Address (include street number, street name, suite, city, state, & zip code):
Phone Number:
Fax Number:
Other Requests:

Unable to Make Contact with a Center:

If for MRI or Biopsy, send email to Leadership and CC the Center Contact using: http://washington-radiology-contact-center.knowledgeowl.com/help/biopsy-mri-etc-contact

All other inquiries, email to Leadership.

SUBJECT LINE: [ENCRYPT] UNABLE TO REACH CENTER

MRN (if applicable):
Patient Name:
Caller Name (if other than the patient):
Contact Number:
Center Name:
Details Regarding Situation:

Diagnostic/Symptomatic Patient Needing Earlier Appointment:

See Symptomatic Patient Needs Sooner Appointment job aid for contact list!

SUBJECT LINE: [ENCRYPT] DX/SYMP PT NEEDING EARLIER APPT

Patient Name:
Medical Record Number (if applicable):
Contact Number:
Exam(s) Requested:
Appointment Set For:
Current Symptoms:

Insurance Verification - Email to Leadership:

SUBJECT LINE: [ENCRYPT] INSURANCE VERIFICATION REQUEST

Medical Record Number (if applicable):
Patient Name:
Caller Name (if other than the patient):
Contact Number:
Procedure/Exam Type:
Center Name:
Insurance Carrier:
Member ID/Policy Number:
Group Number:
Claims Mailing Address:

Complaints/Feedback:

SUBJECT LINE: [ENCRYPT] PATIENT FEEDBACK

Medical Record Number (if applicable):
Patient Name:
Caller Name (if other than the patient):
Is a Return Call Requested: Y/N
Contact Number:
Is the feedback for a Center or the Contact Center: *{Add Center Name or Contact Center}*
Basic Complaint Details:

General Sales :

SUBJECT LINE: [ENCRYPT] GENERAL SALES INQUIRY/REQUEST

Caller Name:
Contact Number:
Company the Represent:
Who are they Requesting to Speak With:
What is the Reason for their Call:
Did they Request a Specific Center/Location (if so, include which one):

Virtual Colonoscopy Exam Scheduled:

Send to the following AND copy Leadership

CENTER	CONTACT
Washington DC	Latessa.Cornell@washingtonradiology.com Sharon.Smith@washingtonradiology.com Keilani.Sprinkle@washingtonradiology.com Lauren.Quick@washingtonradiology.com
Sterling	Samantha.Nibblins@washingtonradiology.com Karen.Peak@washingtonradiology.com Zeyada.Berhane@washingtonradiology.com
Chevy Chase	Harly.Noy@washingtonradiology.com

Patient Name:
MRN:
Scheduled Appointment Date & Time:
Location:

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