# Email Templates

Last Modified on 12/04/2025 1:33 pm EST

# 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<br>Sharon.Smith@washingtonradiology.com<br>Keilani.Sprinkle@washingtonradiology.com<br>Lauren.Quick@washingtonradiology.com |
| Sterling | Samantha.Nibblins@washingtonradiology.com<br>Karen.Peak@washingtonradiology.com<br>Zeyada.Berhane@washingtonradiology.com |
| Chevy Chase | Harly.Noy@washingtonradiology.com |

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

---

## Billing/Refund Inquiry:

**SUBJECT LINE: [ENCRYPT] BILLING/REFUND REQUEST**

Medical Record Number (MRN):
Patient Name:
Caller Name (if not patient):
Patient/Caller Contact Number (if return call needed):
Center Name:
Date of Service:
If applicable, has the patient called the appropriate billing number?
Details of Patient Inquiry/Concern:

---

UPDATED: 12/04/2025

---