

Video Monitored EEG Order Form

Please include a Copy of Insurance Card (Front & Back) & Patient Demographics - Fax: **1-855-326-3876**

PND -0001

(1) Patient Demographics		
Name: _____	DOB: _____	SSN: _____
Address: _____		City/State/Zip: _____
Home Phone: _____		Work/Cell/Alt. Phone: _____
Special Considerations: _____		
Primary Insurance: _____	Ins.ID# _____	Group #: _____
Secondary Insurance: _____	Ins.ID# _____	Group #: _____
***Please attach a copy of demographic sheet, chart notes and insurance card.		

(2) Clinical History - Medicare Accepted ICD Codes - Check all applicable		
	ICD-10	ICD-9
<input type="checkbox"/> F44.4 <input type="checkbox"/> F44.6	Conversion Disorder w motor or sensory symptom or deficit	300.11 - Conversion Disorder
<input type="checkbox"/> G40.A01 <input type="checkbox"/> G40.A11	Absence epileptic syndrome, w/o or w/ intractable, with status epilepticus	345.00 - 345.01 - Gen nonconvulsive epilepsy w/o or w/ intractable
<input type="checkbox"/> G40.309 <input type="checkbox"/> G40.311	Generalized idiopathic epilepsy and epileptic syndromes, w/o or w/ intractable, w/o or w/ status epilepticus	345.1 - 345.11 - Gen convulsive epilepsy w/o or w/ intractable
<input type="checkbox"/> G40.201 <input type="checkbox"/> G40.211	Partial symptomatic epilepsy and epileptic syndromes with complex partial seizures, w/o or w/ intractable, with status epilepticus	345.4 - 345.41 - Partial ep, Cplx w/o or w/ intractable 345.5 - 345.51 - Partial ep, Smpl w/o or w/ intractable 345.7 - 345.71 - Ep partialis continua w/o or w/ intractable
<input type="checkbox"/> G40.101 <input type="checkbox"/> G40.111	Partial symptomatic epilepsy and epileptic syndromes with simple partial seizures, w/o or w/ intractable, with status epilepticus	345.8 - 345.81 - Other forms of epilepsy w/o or w/ intractable
<input type="checkbox"/> G40.901 <input type="checkbox"/> G40.911	Epilepsy, unspecified, w/o or w/ intractable, with status epilepticus	345.9 - 345.91 - Unspecified epilepsy w/o or w/ intractable
<input type="checkbox"/> G40.A01 <input type="checkbox"/> G40.301	Absence epileptic syndrome, not intractable, with status epilepticus Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus	345.2 - 345.3 - Epilepsy, recurrent seizures (petit/Grand Mal)
<input type="checkbox"/> I45.9	Conduction disorder, unspecified	426.9 - Stokes-Adams Syn. (syncope w/ heart block)
<input type="checkbox"/> R40.4	Transient alteration of awareness	780.02 - Transient alteration of awareness
<input type="checkbox"/> R55	Syncope and collapse	780.2 - Syncope and collapse
<input type="checkbox"/> R56.1	Post Traumatic Seizures	780.33 - Post Traumatic Seizures
<input type="checkbox"/> R56.9	Unspecified convulsions	780.39 - Other Convulsions

(3) Procedure Ordered	
<input type="checkbox"/> Long-Term Video Ambulatory EEG	
*Length of Monitoring (Check One) <input type="checkbox"/> 2 Days <input type="checkbox"/> 3 Days <input type="checkbox"/> 5 Days <input type="checkbox"/> Other History: _____	
**All Procedures Include Digital Spike and Seizure Analysis (95957) and ECG	
Other Orders _____	
•Previous EEG <input type="checkbox"/> REEG <input type="checkbox"/> SDEEG <input type="checkbox"/> A-EEG <input type="checkbox"/> EMU	
*If no previous EEG listed above Routine EEG (95816) will be performed if required by payor.	
•Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnorm <input type="checkbox"/> Slowing	

(4) Ordering Physician Information	
Physician Name: _____	Clinic Phone: _____
Address: _____	Clinic Fax: _____
City, State, Zip: _____	NPI#: _____
Check here if the doctor would like to interpret own study: <input type="checkbox"/>	Clinic Contact: _____
Physician Statement: I certify that I am referring the above named patient for long-term electroencephalographic (EEG) monitoring, or video long-term EEG monitoring as listed above, and to the best of my knowledge this test is medically necessary in order to diagnose the patient. I understand that the diagnostic testing provider will not provide a diagnosis nor will they recommend any therapeutic treatment for this patient.	
Physician Signature: _____	Date Ordered: _____

Fax Orders to 1-855-326-3876