Neurodiagnostic Testing Request Form

Date of Service	Referring Physician	Referring Physician Phone	Send Report To: Fax:

Patient Name	Sex	DOB	Patient Phone	Preliminary Diagnosis

Address	Apt #	City	State	Zip	SSN

Subscriber Name - Primary		Subscriber Name - Secondary	
Primary Insurance	Type	Secondary Insurance	Type
Contract No.		Contract No.	
Group No.		Group No.	
Insurance Address		City / State / Zip	
Insurance Phone No.		Worker's Comp. Auth. Number	
Auto Ins. Co. / Claim Number		Adjuster's Name / Adjuster's Phone Number	

- ☐ EMG w/ NCV and Evaluation*
  - ☐ Upper Extremity
  - ☐ Lower Extremity
  - ☐ Both Extremities

Specify: _____

*Basic neurological and musculoskeletal evaluation

Primary Diagnosis: (please circle)

ALS/MND	335.20-29	Lesion of Ulnar Nerve	354.2	Peroneal Palsy	355.3
Bell's Palsy	351.0	Lumbago	724.2	Sciatica	724.3
Brachial Plexus/TOS	353.0	Meralgia Paresthetica	355.1	Tarsal Tunnel Syn.	355.5
Carpal Tunnel	354.0	Myalgia & Myositis	729.1	Thoracic/Lumbar Neuritis or Rad.	724.4
Cervicalgia	723.1	Myasthenia Gravis	358.0		
Cervical Rad./ Brachial Neuritis	723.4	Myopathy (Unspecified)	359.9	Wrist Drop (Acquired)	736.05
Dist. of Skin Sens.	782.0	Peripheral Neuropathy, Unspec.	356.9	Other	

Procedure Codes:

Code	95885 EMG <5 Muscles	95886 EMG ≥5 Muscles	95907 NCV 1-2 Nerves	95908 NCV 3-4 Nerves	95909 NCV 5-6 Nerves	95910 NCV 7-8 Nerves	95911 NCV 9-10 Nerves	95912 NCV 11-12 Nerves	95913 NCV 13+ Nerves
Quantity									

Appointment

Date:_____ Time:_____

Billing Method

- ☐ Global
- ☐ Split

Reason For Ordering Test / Medical Necessity:

- ☐ Basic neurological and musculoskeletal evaluation

_____

Physician's Signature Date

We are committed to protecting patient privacy and abiding by all healthcare regulations including those set forth by HIPAA.

Bone Density Testing Request Form

CareCore AIM MEDSOLUTIONS MOA

ARRIVE 30 MIN PRIOR TO APPT. TIME

BRING THIS SLIP WITH YOU

Date of Service	Referring Physician	Referring Physician Phone	Send Report To: Fax:
Patient Name	Sex	DOB	Preliminary Diagnosis
Address	Ap #	City / State / Zip	SSN
Menopause Age	Ethnicity	Height / Weight	Patient Phone
Subscriber Name - Primary		Subscriber Name - Secondary	
Primary Insurance	Type	Secondary Insurance	Type
Contract No.		Contract No.	
Group No.		Group No.	
Insurance Address		Secondary Insurance Address	
Insurance Phone		Secondary Insurance Phone	

Bone Densitometry Exam

☐ De xa	77080	Axial Skeleton - One or More Sites (Hip & Spine)
☐ IV. (-22) *(In Conjunction with Dexa)*		Instant Vertebral Assessment (T4-L4 Spine; to determine wedge effects)
☐ pD exa	76076	Appendicular Skeleton (peripheral) Distal Region Ulna/Radius (wrist)

Primary Diagnosis

242.90	Hyperthyroidism	275.41	Hypocalcemia
733.00	Osteoporosis - unspecified	627.2	Menopausal or Climacteric States
733.02	Idiopathic Osteoporosis	733.01	Senile Osteoporosis
E9320 & 733.00	Long Term Steroid Therapy	733.09	Other Osteopenia
805.2	FX of Vertebral column w/o mention of spinal cord inj (thoracic closed)		
805.4	FX of Vertebral column w/o mention of spinal cord inj (lumbar closed)		
	Other_____		

Appointment	**Billing Method** *Circle Billing Type*	**Reason For Ordering Test / Medical Necessity**
Date Time	**Global** **Lease**	Physicians Signature Date

We are committed to protecting patient privacy and abiding by all healthcare regulations including those set forth by HIPAA.

Echo/Vascular Testing Referral Form

MOA

Date of Service	Referring Physician	Referring Physician Phone	Send Report To: Fax:

Patient Name	Sex	DOB	Patient Phone	Preliminary Diagnosis

Address	Apt #	City	State	Zip	SSN

Subscriber Name - Primary		Subscriber Name - Secondary	
Primary Insurance	Type	Secondary Insurance	Type
Contract No.		Contract No.	
Group No.		Group No.	

Echo

Echo

☐ 2-D Echo with Doppler and Colorflow	93306
☐ Stress Echocardiogram	93351
	93320
	93325

☐ Angina Pectoris	413.9	☐ Unstable Angina	411.1	☐ CAD (coronary artery disease)	414.00
☐ Chest pain, unspecified	786.50	☐ Chest pain, precordial	786.51	☐ Congestive Heart failure	428.0
☐ Primary Cardiomyopathy	425.4	☐ Shortness of Breath	786.05	☐ Hypertension	402.90
☐ Left Heart Failure	428.1	☐ Old MI	412.		

☐ Aortic Valve insufficiency or stenosis	424.1	☐ Mitral valve insufficiency or prolapse	424.0	☐ Abnormal EKG	794.31
☐ Tricuspid valve insufficiency	424.2	☐ Cardiomegaly	429.3	☐ Mitral Stenosis	394.0
☐ Undiagnosed heart murmur	785.2	☐ Constrictive pericarditis	423.2		

Vascular

Venous

☐ Unilateral	93971
Lower Extremity	
Upper Extremity	
☐ Bilateral	93970
Lower Extremity	
Upper Extremity	

☐ Swelling of Limb	729.81	☐ Chronic Venous Insufficiency	454.1	☐ Postphlebetic Syndrome	459.10
☐ Pulmonary Embolism and Infarction	415.11	☐ DVT of Lower Extremity Acute	453.4	☐ DVT of Lower Extremity Chronic	453.5

☐ Phlebitis and thrombophlebitis (Upper Ext)	451.83	☐ Phlebitis and thrombophlebitis (Lower Ext)	451.19*
☐ Localized superficial swelling, mass / lump	782.2		

Arterial

☐ Lower Extremity Bilateral	93925
☐ Lower Ext. Unilateral - Limited	93926
☐ w/ Segmental Pressure	93923
☐ ABI only	93922
☐ Upper Extremity Bilateral	93930
☐ Upper Ext. Unilateral - Limited	93931
☐ Thoracic Outlet Syndrome	93923
☐ Renal Doppler	93975
☐ Duplex Scan of Aorta	93978

☐ Embolism, thrombosis (lower limb)	444.22	☐ Embolism, thrombosis (upper limb)	444.21	☐ PVD with claudication	440.21
☐ PVD with ischemic rest pain	440.22	☐ Dissection of Renal Artery	443.23		

☐ Raynaud's Disease	443.0	☐ Stricture of artery	447.1	☐ Aneurysm of Renal Artery	442.1
☐ Thrombosis Abdominal Aorta	444.0	☐ Abdominal Aneurysm	441.4		

Cerebral

☐ Carotid duplex with Color Flow	93880
☐ Transcranial	93886

☐ Carotid Artery Stenosis (with CVA)	433.91*	☐ Aphasia	784.3	☐ Disturbance of Skin Sensation	782.0
☐ Hemiplegia & hemiparesis	342.90	☐ Vertigo	386.2	☐ Syncope and collapse	780.2
☐ Transient Visual Loss	368.12	☐ Acute, ill defined, Cerebrovascular Disease (seizure CVA)	436*	☐ TIA	435.9*

☐ Transient Paralysis of Limb	781.4	☐ Lack of coordination	781.3	☐ Other speech disturbance (slurred speech)	784.5
☐ Arterial bruit, weak pulse	785.9	☐ Visual Field Defect	368.40	☐ TIA	435.9
☐ Tinnitus	785.9/388.3	☐ Occlusion / Stenosis Vertebral Artery	433.2	☐ Occlusion / Stenosis Basilar Artery	433.0

Appointment

Date Time

Please Indicate if Patient has

- ☐ BCN
- ☐ HAP
- ☐ PPO
- ☐ HMO *(other)*

Reason For Ordering Test / Medical Necessity

Physician's Signature Date

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Ultrasound Referral Form

CareCore NATIONAL MED SOLUTIONS AIM MOA

Date of Service	Referring Physician	Referring Physician Phone	Send Report To: Fax:

Patient Name	Sex	DOB	Patient Phone	Preliminary Diagnosis

Address	Apt #	City	State	Zip	SSN

Subscriber Name - Primary		Subscriber Name - Secondary	
Primary Insurance	Type	Secondary Insurance	Type
Contract No.		Contract No.	
Group No.		Group No.	

Procedure

Retroperitoneal / Abdominal

☐ Abdominal Ultrasound	76700
☐ Liver	76705
☐ Spleen	76705
☐ Gallbladder	76705
☐ Pancreas	76705
☐ Retroperitoneal	76770
☐ Kidney only or Limited L R	76775
☐ Aorta Doppler	93978
☐ Renal Doppler	93975
☐ Single Organ (Specify)	76705

_____

Small Parts

☐ Thyroid - Neck Soft Tissue	76536
☐ Breast L R	76645
☐ Testicles	76870
☐ Transrectal Prostate	76872
☐ Extremities Soft Tissue	76882
☐ Rotator Cuff	76882
☐ Achilles Tendon	76882

OB GYN / Pelvic

☐ Male Pelvis	76856
☐ Female Pelvis	76856
☐ Transvaginal	76830
☐ Pre & Postvoid Bladder Volumes (pelvic limited)	76857
☐ Obstetrics	76805

Preliminary Diagnosis

☐ RT Upper Quadrant	789.01	☐ Kidney Stone	592.0
☐ RT Lower Quadrant	789.03	☐ Hematuria (idiopathic)	599.7
☐ Epigastric	789.06	☐ Abdominal Aortic Aneurysm	441.4
☐ LT Upper Quadrant	789.02	☐ Renal Artery Aneurysm	442.1
☐ LT Lower Quadrant	789.04	☐ Abdominal Mass	789.30
☐ Low Back Pain	724.2	☐ Urinary Frequency	788.41
☐ Unspecified Liver disease	573.9	☐ Gallbladder Cholelithiasis	574.50
☐ Hepatomegaly (liver)	789.1	☐ Diseased Pancreas	577.9
☐ Calculus (bladder)	594.1	☐ Splenomegaly	789.2

☐ Thyroid Goiter	240.9	☐ Thyroid Nodule	241.0
☐ Breast Mass	611.72	☐ Nocturia	788.43
☐ Dysuria	788.1	☐ Testicular Pain	608.9
☐ Prostate Hypertrophy	600.0	☐ Testicular Mass/Hypertrophy	608.89

☐ Urinary Tract Infection	599.0	☐ Menorrhagia	626.2
☐ Pelvic Mass	789.30	☐ Amenorrhea	626.0
☐ Fibroid (Uterus)	218.9	☐ Dysmenorrhea	625.3
☐ Enlarged Uterus	621.6	☐ Fetal (growth)	649.63
☐ Ovarian Cyst	620.2	☐ Ectopic Pregnancy	633.90
☐ Pelvic Pain	625.8		

Appointment

_____

Date Time

Please Indicate if Patient has

☐ BCN
☐ HAP
☐ PPO
☐ HMO *(other)*

Reason For Ordering Test / Medical Necessity

_____

Physicians Signature Date

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VAT Balance Testing Request Form

Date of Service	Referring Physician: Practice Name:				Referring Physician Phone			Send Report To: Fax:	
Patient Name		Sex	DOB	Patient Phone			Preliminary Diagnosis		
Address		Apt #	City		State	Zip	SSN		
Menopause Age	Ethnicity				Weight			Height	
Subscriber Name - Primary					Subscriber Name - Secondary				
Primary Insurance			Type		Secondary Insurance			Type	
Contract No.					Contract No.				
Group No.					Group No.				
Insurance Address					City		State	Zip	
Primary Insurance Phone No.					Secondary Insurance Phone No.				

VAT

❑92542	Positional Nystagmus
❑92547	Use of Vertical Electrodes X 3
❑92546	Sinusoidal Rotation Test X 2
❑ 92270	Electro-Occulography

Primary		Secondary	
❑389.10	Semsorineural hearing loss	❑ 780.4	Dizziness
❑ 386.2	Vertigo of the Central Origin	❑ 781.2	Imbalance Origin
❑ 386.10	Peripheral Vertigo, unspecified		
❑ 386.9	Vertiginous syndromes and other disorder of the vestibular system	❑ V15.88	History of Falls – At risk for falling

Appointment	Billing Method	Reason For Ordering Test / Medical Necessity:
Date:_____ Time:_____	❑ Global ❑ Lease	_____ Physician's Signature Date

We are committed to protecting patient privacy and abiding by all healthcare regulations including those set forth by HIPAA.

Nuclear/Stress Testing Referral Form

Toll Free: (800) 342-8921
Fax: (248) 827-2641

STAT Appointments Available

Date	Referring Physician	Phone	Send Report To: Fax:
Patient Name Patient Phone		DOB	Preliminary Diagnosis

ARRIVE 30 MIN PRIOR TO APPT. TIME

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Nuclear Medicine

- ☐ Nuclear Stress Test w/ Functions (SPECT)
- ☐ Persantine w/Above
- ☐ MUGA with First Pass
- ☐ Bone Scan ·Whole Body ·3-Phase Attn:_____ (SPECT)
- ☐ Renal Scan w/Flow (SPECT)
- ☐ Liver/Spleen Scan (SPECT)
- ☐ HIDA (Gallbladder)
- ☐ Tc-99m Thyroid Scan
- ☐ I-123 Thyroid Uptake & Scan (2-day procedure)
- ☐ Scintimammography
- ☐ Gallium Scan
- ☐ Brain Scan w/Dynamic Flow (SPECT)
- ☐ Testicular Scan
- ☐ Other SPECT Scans: _____

Patients who do not show up for their appointments and fail to give 24-hr notice will be charged $200

Patient Initials: _____

Don't Forget!
we also offer

40-Slice CT / CTA • Stress Echo • EMG / NCV
Ultrasound • Vascular Studies • Digital Mammography
Digital X-Ray • Bone Densitometry

Appointment	**Please Indicate if Patient has**	**Reason For Ordering Test / Medical Necessity**
Date _____ Time	☐ BCN ☐ PPO ☐ HMO *(other)*	Physicians Signature _____ Date