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.