



Quality Testing at Your Convenience

Patient Name		Date of Birth	
Address		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip	
Phone (Home)	Phone (Cell)	Phone (Work)	
Patient Insurance	Subscriber ID	Group ID #	Insurance Phone #

Please Send Copy of Order, Scan of Insurance Card and PT Hx to:

FAX: 866-859-7105

*****Routine EEG must be ordered or completed prior to any Video EEG services*****

Please choose from the following DX codes which are universally acceptable by all insurances for an EEG

- F44.5 Conversion Disorder with Seizures
- G40.009 Focal Non-Intractable Epilepsy and Recurrent Seizures
- G40.019 Focal Intractable Epilepsy and Recurrent Seizures
- G40.209 Localization-related (focal)(partial) Symptomatic Epilepsy
- G40.309 Generalized Non-Intractable Nonconvulsive Epilepsy
- G40.319 Generalized Intractable Nonconvulsive Epilepsy
- G40.919 Unspecified Intractable Epilepsy
- G40.909 Unspecified Non-Intractable Epilepsy
- R55 Syncope and Collapse
- R56.1 Post Traumatic Seizures
- R56.9 Other Convulsions or Spells

OFFICE USE ONLY

Drive Time: _____
 Call Log: _____

 Scheduled: _____
 Test Info: _____

CPT Code	Activations	Contact Us:
<input checked="" type="checkbox"/> 95813 Extended EEG Monitoring > 1hr	<input type="checkbox"/> HV <input type="checkbox"/> Photic <input type="checkbox"/> Sleep Deprivation <input type="checkbox"/> Other: <input type="checkbox"/> All Above	Fax: 866-859-7105 Billing: 317-333-7390 Scheduling: 317-804-9652

All EEG setups and monitoring are performed and/or supervised by a Registered EEG Technologist certified by the American Board of Registered Electroencephalographic Technologists which will perform EEG monitoring services by cable/radio 16 channel or more telemetry.

Study Notes: 95813 Extended EEG monitoring > 1hr is used to help ensure a more comprehensive study and an increased likelihood of capturing sleep.

The referring physician who submits this order/verification form is hereby giving authorization to allow In Home Neurodiagnostics to perform an EEG on this patient. The referring physician has acknowledged the duration, monitoring and technologist requirement. Both the referring and interpreting physicians are aware of the EEG equipment capabilities.

Referring Physician _____ Phone: _____

Referring Physician Email (optional): _____

Interpreting Physician: _____ Phone: _____

Referring Physician Signature: _____ Date: _____

(Signature above is referring physician or by an authorized representative of the referring physician)

Email or Fax results to: _____



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*****Routine EEG must be ordered or completed prior to any Video EEG services*****

Has Patient had Routine EEG: Yes No If Yes, please include the report along with demographics and H&P
(within past year) If No, please order one prior to Video EEG acquisition

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<p>Video EEG Duration</p> <p><input type="checkbox"/> 24 Hour <input type="checkbox"/> 96 Hour <input type="checkbox"/> 48 Hour <input type="checkbox"/> 120 Hour <input type="checkbox"/> 72 Hour</p> <p>**Activations with Routine EEG Only**</p>	<p>Contact Us:</p> <p>Fax: 866-859-7105</p> <p>Billing: 317-333-7390</p> <p>Scheduling: 317-804-9652</p>
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Interpreting Physician: _____ Phone: _____

Referring Physician Signature: _____ Date: _____

(Signature above is referring physician or by an authorized representative of the referring physician)

Email or Fax results to: _____