

TO ORDER A LONG-TERM VIDEO EEG  
 FAX THIS COMPLETED FORM TO:  
 E-FAX: (803)-526-7349 or  
 FAX: (803)-451-0407



CERTIFICATE OF MEDICAL NECESSITY - VIDEO EEG REFERRAL FORM

PATIENT DEMOGRAPHICS

Patient's Name \_\_\_\_\_ SSN# \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

INSURANCE & CARDHOLDER INFORMATION

**Primary** Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Payor ID#: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cardholder Name: \_\_\_\_\_ SSN #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary** Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Payor ID#: \_\_\_\_\_  
 Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Cardholder Name: \_\_\_\_\_ SSN #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male / Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

OBJECTIVE OF TEST

- Spell Characterization     Differential Diagnosis     Seizure Classification     Monitor Interictal Change  
 Cardiogenic Origin     Evaluate Epilepsy     Sleep Disturbances     Other: \_\_\_\_\_

EEG LENGTH OF MONITORING

- 72 Hours w/ Video & Digital Analysis     Extended EEG 1-8 hrs w/ Digital Analysis     Other: \_\_\_\_\_  
 5 Days w/ Digital Analysis     7 Days w/ Digital Analysis     Long Term Monitoring w/ Digital/SA (number of days) \_\_\_\_\_

Montage: 27 Channel w/ Remontaging or 18 Channel w/ Double Banana

<input type="checkbox"/> G40.909   Epilepsy, Unspecified, not Intractable	<input type="checkbox"/> G40.919   Epilepsy, Unspecified, Intractable	<input type="checkbox"/> G40.109   Simple Partial Epilepsy, not Intractable
<input type="checkbox"/> G40.319   Generalized Epilepsy, Intractable	<input type="checkbox"/> G40.A19   Absence Epileptic Syndrome, Intractable without Status Epilepticus	<input type="checkbox"/> G40.309   Generalized Epilepsy, not Intractable
<input type="checkbox"/> R55   Syncope and Collapse	<input type="checkbox"/> G40.89   Other Seizures	<input type="checkbox"/> R41.82   Altered Mental Status, Unspecified
<input type="checkbox"/> R25.8   Other Abnormal Involuntary Movements	<input type="checkbox"/> R56.9   Unspecified Convulsions	<input type="checkbox"/> F44.5   Conversion Disorder
<input type="checkbox"/> G40.119   Simple Partial Epilepsy, Intractable	<input type="checkbox"/> G40.209   Complex Partial Epilepsy, not Intractable	<input type="checkbox"/> G40.219   Complex Partial Epilepsy, Intractable

Primary Dx 1 \_\_\_\_\_ Secondary Dx 2 \_\_\_\_\_

READING PHYSICIAN SAME AS ORDERING PHYSICIAN     YES     NO

ORDERING PHYSICIAN

Ordering Physician (Please Print): \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*I certify that to the best of my knowledge, this test and any interpretation is medically necessary in order to provide information which will assist in proper diagnosis and/or treatment in the management of the above-named patient.*

Ordering Physician's Signature

Date

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