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

PALMETTO DIAGNOSTICS
YOUR LONG TERM EEG PARTNER

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

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