

LEO GERMIN, MD, FAANEM
&
NEUROLOGICAL
ASSOCIATES



CONTACT:
☎ SCHEDULING: (702) 804-4949
☎ FAX: (702) 577-0985
SERVICES:
Neurological Consultation & Treatment
NCV/EMG, EEG, Video EEG, TCD

STEP I: ENTER PATIENT INFORMATION: 4 STEP REFERRAL FORM

REFERRAL DATE: ____/____/____

PATIENT NAME:		DOB: / /	SSN:	EMAIL:
PATIENT ADDRESS (Street):		(City):	(State and Zip):	
CELL PHONE (Please Provide):	WORK / ALT. PHONE:		HOME PHONE:	
REF. PHYSICIAN / CLINIC:	PHONE:	FAX:	FAX CONTACT:	
PATIENT DUE BACK IN THE OFFICE ON: / /	OTHER INFORMATION:			

STEP 2: CHOOSE THE PAYER SOURCE: (Some sources require prior auth. Please call with any questions)

INSURANCE

INSURANCE (Primary): <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other	INSURANCE (Secondary): <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other	AUTHORIZATION #:	REFERRING DATE: ____/____/____
OTHER INFORMATION (Authorization Expiration Date, etc...):			

WORKERS' COMPENSATION

WORKERS' COMPENSATION COMPANY:	CLAIM #, DOI ADJUSTER:	PHONE:
OTHER INFORMATION (DOI, Adjuster, etc...):		

MEDPAY **MEDICAL LIEN** **OTHER:** _____

PAYER:	ADDRESS:		
CLINIC / ATTY / FIRM:	PHONE:	FAX:	FAX CONTACT:

STEP 3: CHOOSE A SERVICE: (Some services require prior auth. Please call with any questions)

<p>MOST COMMON CPT CODES AND (UNITS REQUIRED)</p> <p><input type="checkbox"/> CONSULTING 99245 (1)</p> <p><input type="checkbox"/> TESTING</p> <p><u>NCV / EMG / EDX / CONSULT</u></p> <p><input type="checkbox"/> UPPER <input type="checkbox"/> LOWER</p> <p><input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT (UNILATERAL) 95910 (1), 95886 (1), 99243 (1)</p> <p><input type="checkbox"/> BILATERAL 95913 (1), 95886 (2), 99243 (1)</p> <p><u>EEG</u></p> <p><input type="checkbox"/> EEG 95812 (1), 95957 (1)</p> <p><input type="checkbox"/> AMBULATORY EEG 95953 (2), 95957 (1)</p> <p><input type="checkbox"/> VIDEO EEG 95951 (2), 95957 (1)</p>	<p>MOST COMMON ICD-10 CODES</p> <p><input type="checkbox"/> ABNORMAL BRAIN SCAN R94.02 <input type="checkbox"/> BACK PAIN M54.5</p> <p><input type="checkbox"/> OTHER SEIZURES G40.89 <input type="checkbox"/> CARPAL TUNNEL UNS G56.00</p> <p><input type="checkbox"/> DEMENTIA F02.80 <input type="checkbox"/> DIZZINESS/GIDDINESS R42</p> <p><input type="checkbox"/> GAIT DISORDER R26.0 <input type="checkbox"/> HEADACHE R51</p> <p><input type="checkbox"/> LOWER LEG PAIN M79.609 <input type="checkbox"/> MEMORY LOSS R41.2</p> <p><input type="checkbox"/> MUSCLE WEAKNESS M62.81 <input type="checkbox"/> NECK PAIN M54.2</p> <p><input type="checkbox"/> NUMBNESS R20.2 <input type="checkbox"/> SLURRED SPEECH R47.81</p> <p><input type="checkbox"/> SYNCOPE R55 <input type="checkbox"/> STROKE I63.50</p> <p><input type="checkbox"/> TREMORS/TWITCHES G25.0 <input type="checkbox"/> ULNAR NERVE INJURY G56.20</p> <p><input type="checkbox"/> Other ICD10 CODES/SYMPTOMS: _____</p>
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STEP 4: FAX THIS FORM, PROGRESS NOTES, ID, INS. CARD, AVAILABLE RECORDS TO OUR SECURE FAX: (702) 577-0985

SEE THE REVERSE SIDE OF THIS REFERRAL FORM FOR ADDITIONAL INFORMATION