

REFERRAL FORM FOR NERVE CONDUCTION STUDY, EMG OR STERIOD INJECTION

Fax completed form to 803.254.2825.

1910 Blanding Street * Columbia, SC 29201 * 803.256.4107
www.midlandsortho.com

Referring Physician Information		
Name:	Contact Person:	
NPI:		
Address:		City, State, Zip:
Phone:	Ext:	Fax:

Patient Information		
Name:	Address:	
SSN:		City, State, Zip:
DOB:		
Home Phone:	Work Phone:	Mobile Phone:

Please check the requested service. These services are performed in our office setting and only require pre-certification of the professional service.

() One Side Upper Extremity		() Two Side Upper Extremity	
95904	x 2 or more sensory (NCS) study	95904	x 4 or more sensory (NCS) study
95900	x 2 or more motor (NCS) study	95900	x 4 or more motor (NCS) study
95860	x 1 EMG – one extremity	95861	x 1 EMG –one extremity
() One Side Lumbar Radiculopathy		() Two Side Lumbar Radiculopathy	
95904	x 1 sensory (NCS) study	95904	x 1 sensory (NCS) study
95903	x 2 “F” wave and motor NCS study	95903	x 2 “F” wave & Motor NCS study
95934	x 2 H-Reflex (NCS)	95934	x 2 H-Reflex (NCS)
95860	x 1 EMG – two extremity	95861	x 1 EMG – two extremity
() Pudendal Nerve Study			
95900	x 4 motor exam (NCS)		
A4556	x 1 supply code		

Symptom or rule out: _____

The following services are performed at Midlands Orthopaedics Surgery Center, 1930 Blanding Street, Columbia, SC 29201. Please obtain precertification for both the professional service and the facility fee.

() 62311 LESI	() 62310 CESI	() 64483 Transforaminal	() 20610 HIP														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: left;">() Other:</td> <td rowspan="5" style="width: 20%; text-align: center; vertical-align: middle;"> These supplies are required for each injection. </td> </tr> <tr> <td>A4550</td> <td>x 1 Disposable Tray</td> </tr> <tr> <td>77003</td> <td>x 1 Lumbar Spine X-Ray</td> </tr> <tr> <td>J0702</td> <td>x 1 Celestone, per 3 mg</td> </tr> <tr> <td>Q9966</td> <td>x 1 Isovue, per ml</td> </tr> <tr> <td>Facility fee</td> <td colspan="2">Please make the insurance company aware of this charge for procedures performed in the Surgery Center.</td> </tr> </table>				() Other:		These supplies are required for each injection.	A4550	x 1 Disposable Tray	77003	x 1 Lumbar Spine X-Ray	J0702	x 1 Celestone, per 3 mg	Q9966	x 1 Isovue, per ml	Facility fee	Please make the insurance company aware of this charge for procedures performed in the Surgery Center.	
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Facility fee	Please make the insurance company aware of this charge for procedures performed in the Surgery Center.																

Please reference the codes for each procedure when obtaining authorization.
Facility authorizations are required for injections only, not nerve conduction studies or EMGs.

INSURANCE INFORMATION AND AUTHORIZATION	
Primary:	Phone Number:
Professional Services Authorization Number:	Facility Authorization Number:
Secondary:	Phone Number:
Professional Services Authorization Number:	Facility Authorization Number:

Please provide the patient with any pertinent office notes or images that may be needed to perform the requested test.

We will contact the patient to schedule an appointment date and time as soon as this completed form is received documenting appropriate insurance authorization. Please fax the form to 803.254.2825.