Long Term Video Ambulatory EEG
Order Form

INTEGRIS NEURO

Email to
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Fax to
1-877-492-1768 / Alt. Fax
1-877-944-2111

Procedure: ☑ **Long Term Video Ambulatory EEG** ☐ **Routine EEG**

Length of Video Intermittent Monitoring (Select One)

☐ **1 Day** ☐ **2 Days** ☐ **3 Days** ☐ **4 Days**

☐ **Other** _____
Description

_____ _____ _____
Patient (Last, First) DOB Sex (M/F)

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____
Patient Phone Number Parent/Guardian Name (Required For Minors) Parent/Guardian Phone #

_____ _____
Primary Insurance Secondary Insurance

_____ _____
Primary Insurance (Member ID) Secondary Insurance (Member ID)

Commercial, Medicare & Medicaid Accepted Codes

Check All That Apply

- ☐ **G40.009** Focal partial idiopathic epilepsy, localized, not intractable
- ☐ **G40.019** Focal partial idiopathic epilepsy, intractable
- ☐ **G40.109** Focal partial w/ simple partial seizures, not intractable
- ☐ **G40.209** Focal partial w/ complex partial seizures, not intractable
- ☐ **G40.219** Focal partial w/ complex partial seizures, intractable
- ☐ **G40.309** Gen idiopathic epilepsy, not intractable
- ☐ **G40.319** Gen idiopathic epilepsy, intractable
- ☐ **G40.409** Other gen epilepsy, not intractable
- ☐ **G40.419** Other gen epilepsy, intractable
- ☐ **G40.802** Other epilepsy, not intractable
- ☐ **G40.804** Other epilepsy, intractable
- ☐ **G40.812** Lennox-Gastaut syndrome, not intractable
- ☐ **G40.814** Lennox-Gastaut syndrome, intractable
- ☐ **G40.89** Other seizures
- ☐ **G40.909** Epilepsy, unspecified, not intractable
- ☐ **G40.919** Epilepsy, unspecified, intractable
- ☐ **G40.A09** Absence epileptic syndrome, not intractable
- ☐ **G40.A19** Absence epileptic syndrome, intractable
- ☐ **G40.B09** Juvenile myoclonic epilepsy, not intractable
- ☐ **G40.B19** Juvenile myoclonic epilepsy, intractable
- ☐ **R41.82** Altered mental status, unspecified
- ☐ **R55** Syncope and collapse (NOT ACCEPTED BY MEDICAID)
- ☐ **R56.1** Post traumatic seizures
- ☐ **R56.9** Unspecified convulsions

Codes Only Accepted By Medicare

- ☐ **F44.4** Conversion disorder with motor symptom or deficit
- ☐ **F44.6** Conversion disorder with sensory symptom or deficit
- ☐ **R40.4** Transient alteration of awareness

Codes Only Accepted By Medicaid

- ☐ **F05** Delirium caused by known physiological condition
- ☐ **F06.0** Psychotic disorder with hallucinations, known physiological condition
- ☐ **F06.8** Other specified mental disorders due to known physiological condition
- ☐ **G25.3** Myoclonus
- ☐ **G31.01** Pick's Disease
- ☐ **G31.09** Other Frontotemporal neurocognitive disorder
- ☐ **G31.83** Neurocognitive disorder with Lewy bodies
- ☐ **G40.001** Focal partial idiopathic epilepsy
- ☐ **G40.119** Focal partial epilepsy w/ simple partial seizures, intractable
- ☐ **G40.509** Epileptic seizures related to external causes, not intractable
- ☐ **G40.C09** Lafora progressive myoclonus epilepsy, not intractable
- ☐ **G40.C19** Lafora progressive myoclonus epilepsy, intractable
- ☐ **G91.2** Idiopathic normal pressure hydrocephalus
- ☐ **R41.0** Unspecified disorientation
- ☐ **R41.1** Anterograde amnesia
- ☐ **R56.01** Complex febrile convulsions
- ☐ **S060X1A** Concussion with LOC, 30 min or less, initial encounter
- ☐ **S060X1D** Concussion with LOC, 30 min or less, subsequent encounter
- ☐ **S060X1S** Concussion with LOC, 30 min or less, sequela
- ☐ **S060XAA** Concussion with LOC, status unknown
- ☐ **S060XAD** Concussion with LOC, status unknown, subsequent encounter
- ☐ **S060XAS** Concussion with LOC, status unknown, sequela

_____
Ordering Physician

_____ _____
Phone # Fax #

_____
Address

_____
Address 2

_____ _____
NPI # Physician Office Contact

Does patient have follow-up visit scheduled? ☐ Yes ☐ No

If Yes, when? _____

Has the patient had a routine EEG? ☐ Yes ☐ No

If Yes, when? _____

Interpreting Physician

☐ Self (Same as referring physician)

☐ Other _____

Physician Statement

I certify that I am referring the above named patient for long-term electroencephalographic (EEG) monitoring, or long-term EEG monitoring as listed above, and to the best of my knowledge this test is medically necessary in order to diagnose the patient. I understand that the diagnostic testing provider will not provide a diagnosis nor will they recommend any therapeutic treatment for this patient.

_____
Physician Signature

_____
Date

PLEASE SEND COPIES OF FRONT & BACK OF INSURANCE CARDS, PATIENT DEMOGRAPHIC SHEET, CLINICAL NOTES & ROUTINE EEG REPORT.