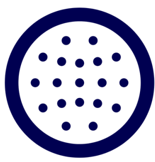

Mobile Cardiac Telemetry
Order Form

Procedure: ☑ **Mobile Cardiac Telemetry**

☐ 2 Days ☐ 3 Days ☐ 4 Days

☐ **Additional Orders:**

Description

Patient (Last, First) | DOB | Sex (M/F) | Primary Language

Address | City | State | Zip Code

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

Primary Insurance | Secondary Insurance

Primary Insurance (Member ID) | Secondary Insurance (Member ID)

Medicare Accepted ICD-10 Codes
Check All That Apply

☐ **R42** **Dizziness and giddiness**

☐ **R55** **Syncope and collapse**

☐ **G45.9** Transient cerebral ischemic attack, unspecified
☐ **I44.0** Atrioventricular block, first degree
☐ **I44.1** Atrioventricular block, second degree
☐ **I44.2** Atrioventricular block, complete
☐ **I44.30** Unspecified atrioventricular block
☐ **I45.6** Pre-excitation syndrome
☐ **I45.89** Other specified conduction disorders
☐ **I47.0** Re-entry ventricular arrhythmia
☐ **I47.1** Supraventricular tachycardia
☐ **I47.2** Ventricular tachycardia
☐ **I47.9** Paroxysmal tachycardia, unspecified
☐ **I48.0** Paroxysmal atrial fibrillation
☐ **I48.11** Longstanding persistent atrial fibrillation
☐ **I48.19** Other persistent atrial fibrillation
☐ **I48.20** Chronic atrial fibrillation, unspecified
☐ **I48.21** Permanent atrial fibrillation
☐ **I48.3** Typical atrial flutter
☐ **I48.4** Atypical atrial flutter
☐ **I48.91** Unspecified atrial fibrillation
☐ **I48.92** Unspecified atrial flutter
☐ **I49.2** Junctional premature depolarization
☐ **I49.5** Sick sinus syndrome
☐ **I67.841** Reversible cerebrovascular vasoconstriction syndrome
☐ **I67.848** Other cerebrovascular vasospasm and vasoconstriction
☐ **R00.0** Tachycardia, unspecified
☐ **R00.1** Bradycardia, unspecified
☐ **R00.2** Palpitations
☐ **Z79.01*** Long term (current) use of anticoagulants

Ordering Physician

Phone # | Fax #

Address

Address 2

NPI # | Physician Office Contact

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

If Yes, when? ____/____/____

Interpreting Physician
☑ Integris Neuro Cardiologist

Physician Statement
I certify that I am referring the above named patient for mobile cardiac telemetry 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

Email to **admin@integrisneuro.com** or Fax to **1-877-492-1768** / Alt. Fax **1-877-944-2111**