Strakowski Ultrasound Referral Form

Patient Name: _____ **DOB:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Numbers: Cell: _____ **Home:** _____

Insurance: *Dr. Strakowski is OON with ALL Medicaid plans (primary and/or secondary)*

Primary Insurance: _____

Member ID#: _____ **Group #:** _____

Insured Name/DOB/Relationship: _____

Secondary Insurance: _____

Member ID#: _____ **Group #:** _____

Insured Name/DOB/Relationship: _____

Reason for Referral: Circle:

EMG	US	Both	
Left	Right	Bilateral	
Upper Ext	Lower Ext	Other _____	

Referring Provider: _____

Office Phone Number:_____ **Office Fax Number**: _____

Please include the following with this referral form:

- ☐ Images of Insurance card(s) front/back
- ☐ Last office note and/or previous testing
- ☐ BWC C-9/Authorization forms

The CPT Codes for US needed on C-9 are: 99204, 76881, 76883. We are currently scheduling ~6-8 weeks out. We are unable to schedule without an approved C-9 authorization form.

Thank you for your referral!

1210 Gemini Place, Suite 200 Phone: 614.324.8177 Fax: 614.310.7421