Strakowski Ultrasound Referral Form

Patient Name: _____ **DOB:** _____

Patient Address: _____

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

SSN: _____ **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 with ICD-10 Code : _____

_____

Reason for Referral: Circle: EMG US Both

Left Right Bilateral

Upper Ext Lower Ext Other _____

Referring Provider: _____

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

The following is <u>required</u> before we schedule the patient --

- ☐ 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.

The CPT Codes for EMG needed on C-9 are: 99204, 95886, 95907-95912

Referrals are worked in the order in which they are received. Dr. Strakowski is currently scheduling ~ 6-8 weeks out. We are unable to schedule without a completed referral form, and if BWC, an *approved* C-9 authorization form.

Thank you for your referral!

Internal Use Only:

Date Referral Received: _____ MRN:_____ **INN/ONN** Prepay _____

Notes: _____

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