Physician's Orders and Certificate of Medical Necessity Form

ORDERING PHYSICIAN INFO

_____
DATE

_____
PHYSICIAN'S NAME

_____
PHYSICIAN'S PHONE

_____
ADDRESS

_____
CITY STATE
ZIP

_____
MEDICAL FACILITY

_____
OEDERING FAX NUMBER

_____
DX / SYMPTONS

_____

_____

_____

ON-SITE SERVICES ORDERED

EMG / NCV _____

CONSULTATION _____

BOTOX _____

TRIGER POINT INJECTIONS _____

_____ BOTH ARMS

_____ BOTH LEGS

_____ LEFT ARM

_____ LEFT LEG

_____ RIGHT ARM

_____ RIGHT LEG

_____ NECK

_____ LUMBAR-SACRAL BACK

_____ SHOULDER LEFT

_____ SHOULDER RIGHT

NEW PATIENT INFORMATION

PATIENT'S NAME: _____ MALE _____ FEMALE _____

ADDRESS: _____ APT.# _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE _____

DATE OF BIRTH: _____ AGE ____ SOC. SECURITY # _____

PRIMARY INSURANCE INFORMATION

PRIVATE/INDEMNITY _____ PPO _____ HMO _____ WORKERS COMPENSATION _____

PERSONAL INJURY _____ AUTO _____ MEDICARE _____

PRIMARY INSURANCE _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ PHONE NUMBER _____ INSURED NAME _____

GROUP NUMBER _____ SOC. SECURITY # _____

INSURED EMPLOYER _____

SECONDARY INSURANCE INFORMATION

PRIVATE/INDEMNITY _____ PPO _____ HMO _____ WORKERS COMPENSATION _____

PERSONAL INJURY _____ AUTO _____ MEDICARE _____

PRIMARY INSURANCE _____

ADDRESS _____ CITY _____ STATE _____

ZIP _____ PHONE NUMBER _____ INSURED NAME _____

GROUP NUMBER _____ SOC. SECURITY # _____

INSURED EMPLOYER _____

WORKER COMPENSATION AND OTHER INSURANCE INFORMATION

DATE OF INJURY _____ / _____ / _____

ATTORNEY NAME _____

ATTORNEY PHONE _____ CLAIM NUMBER _____

CARRIER NAME _____ CARRIER PHONE _____

ORDERING PHYSICIAN STATEMENT:

I certify that I am ordering specified services for the above named patient. I, as the ordering physician for services described in this request, certify that to my best knowledge, that the tests and any interpretation required is medically necessary in order to provide information which will assist in the proper diagnosis and/or treatment management for the above named patient. I understand that the tests ordered, and any interpretation, that I receive are intended to supplement my diagnosis of this patient's condition.

_____
SIGNATURE

REFERRED TO:

COMMUNITY NEUROLOGIC CENTER

2401 KANEVILLE RD., SUITE 8, GENEVA, IL 60134, TEL. 630-208-7735, FAX 630-208-6956