BIOSERENITY
Smart Healthcare Solutions

Certificate of Medical Necessity

Please Fax Completed Referral, Copy of Insurance Card and Notes to: 610-543-8051

1 - SELECT ROUTINE EEG:

- ☐ **95816 – EEG awake and drowsy**
- ☐ **95819 – EEG awake and asleep**
- ☐ **Photic Stimulation (if available)**
- ☐ **Hyperventilation**

2- INTERMITTENT MONITORED AMBULATORY EEG:

☐ **Amb VIDEO EEG or** ☐ **Amb EEG ONLY** No Video

includeS Tech Setup/DC code: 95700

☐ **Photic Stimulation (if available)** ☐ **Hyperventilation**

☐ **Custom Order** _____

3 - RECOMMENDED LENGTH OF TESTING

☐ **Up to 98 hours** ☐ **74-84 hours** ☐ **60-74 hours**

☐ **50-60 hours** ☐ **36-50 hours** ☐ **26-36 hours**

☐ **Other:** _____

CLINICAL SYMPTOMS

- ☐ **R55** Syncope and collapse
- ☐ **R56.9** Unspecified convulsions
- ☐ **G40.A09** Absence syndrome, not intractable, without status epileptic
- ☐ **G40.209** Localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable, without status epilepticus
- ☐ **G40.219** Localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures intractable without status epilepticus
- ☐ **G40.309** Generalized idiopathic epilepsy and epileptic syndromes, not intractable without status epilepticus
- ☐ **G40.409** Other generalized epilepsy and epileptic syndromes, not intractable, without status
- ☐ **G40.909** Epilepsy, unspecified, not intractable, without status epilepticus
- ☐ **Other**: _____

MEDICATIONS: _____

_____

PREVIOUS EEG HISTORY

Routine EEG: _____

Please attach EEG report

PATIENT NAME:

_____

Address: _____

_____

Phone: _____

DOB: _____ **M/F:** _____

Primary Insurance: _____

ID: _____

Secondary Insurance: _____

ID: _____

SELECT AN INTERPRETING PHYSICIAN

☐ Referring Physician/Self

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

Office Contact: _____

Referring Physician Statement:

I certify to the best of my knowledge that this test and any interpretation is medically necessary in order to diagnose my patient.
I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition. I recognize that BioSerenity,Inc will not provide a diagnosis of this patient nor will BioSerenity, Inc recommend any therapeutic measures for this patient.

PHYSICIAN SIGNATURE:

_____

DATE: _____

BioSerenity, Inc.

site according to patient zip code

Phone: 610-543-6800