



SCHEDULING FORM

Fax: 866-832-1480

Please fully complete this form and fax it to the number below. Thank you for your cooperation.

PATIENT AND HOSPITAL INFORMATION

PATIENT NAME: _____ DOB.: _____

GENDER: MALE [] FEMALE [] SOCIAL SECURITY #: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

HOSPITAL: _____ SURGEON: _____

SURGICAL PROCEDURE/LEVEL _____ SURGERY DATE: _____

DIAGNOSIS /CODES: _____ START TIME: _____ DURATION: _____

INSURANCE INFORMATION

NUMBER OF INSURANCE CARRIERS: _____ IF THERE ARE MORE THAN ONE, PLEASE COMPLETE ADDITIONAL FORMS AS NEEDED. IF YOU HAVE A FACE SHEET OR COPY OF THE INSURANCE CARD, PLEASE FAX THOSE AS WELL.

INSURANCE CARRIER: _____ INS ID #: _____

GROUP NAME: _____ GRP #: _____

PHONE#: _____ PRE-CERT#: _____

INS ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ RELATIONSHIP TO INSURED: SELF [] SPOUSE [] CHILD [] OTHER []

IF THE PATIENT IS NOT THE POLICY HOLDER, PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE POLICY HOLDER

NAME: _____ DOB: _____ SS#: _____

PHONE#: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ACCIDENT OR JOB RELATED INFORMATION

INJURED ON JOB: YES [] NO [] DATE OF INJURY: _____ EMPLOYER: _____

MOTOR VEHICAL ACCIDENT: YES [] NO [] DATE OF ACCIDENT: _____

CLAIM #: _____

TEST REQUESTED: (PLEASE CIRCLE APPROPRIATE TEST)

USSEP	MEP	DIRECT NERVE STIMULATION	OTHER (PLEASE SPECIFY
LSSEP	BAEP	PHASE REVERSAL	_____
SEMG	VEP	DIRECT CORTICAL STIMULATION	
TEMG	EEG	TCeMEP	

*** Neuromonitoring tests must be authorized. Signing below, affirms that the doctor responsible for the above named patient's care has authorized intraoperative monitoring using the testing modalities indicated from Sentient Medical Systems on the date specified above.**

SIGNATURE OF ORDERING PHYSICIAN: _____ DATE FAXED TO SMS: _____

(Print Physician Name) _____ PHYSICIAN UPIN # _____

CONTACT: Scheduling Team Telephone: 866-832-1438, x0 Fax: Refer to number at top of form

THIS FORM SERVES AS A CERTIFICATE OF MEDICAL NECESSITY