



ORDER FORM

To schedule NeuroCare services, please complete this form and fax it to (866) 832-1480.
Scheduling Team Phone: (410) 666-2397 X129

PATIENT INFORMATION

PATIENT NAME: _____

DOB: _____

REQUESTED DATE AND TIME FOR TEST: _____

FACILITY: _____

REASON FOR TEST: _____

ORDERING PHYSICIAN: _____

NEUROCARE TEST/S TO BE ORDERED

NORMAL TCD (CPT Code 93886)

TCD EMBOLI MONITORING (CPT Code 93892)

BUBBLE TCD (CPT Code 93893)

TCD VASOREACTIVITY EVALUATION (CPT Code 93890)

CAROTID DUPLEX (CPT Code 93880)

EEG (CPT Code 95816)

INSURANCE INFORMATION

NUMBER OF INSURANCE CARRIERS: _____ IF THERE IS 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 []

SIGNATURE OF PERSON COMPLETING FORM: _____

PRINTED NAME OF PERSON COMPLETING FORM: _____

FACILITY CONTACT PHONE NUMBER (in case of questions): _____

DATE FAXED TO SMS: _____

FAX NUMBER WHERE SMS SERVICE CONFIRMATION CAN BE SENT: _____