

**NEUROALERT MONITORING SERVICES
244 WESTCHESTER AVENUE, SUITE 316
WHITE PLAINS, NEW YORK 10604
TEL. (914) 949-8501 / FAX (914) 949-8502**

REQUEST FOR NEUROPHYSIOLOGIC INTRA-OPERATIVE MONITORING SERVICES

Date: ___/___/___ Requesting Doctor: _____ Hospital: _____

Date of Surgery: ___/___/___ Scheduled Start Time: _____ AM ___ PM ___

Length of Procedure: _____ (Note: All cases will be verified 24 hours before surgery. Please call our office if you don't hear from us.)

Type of Surgery (include levels): _____

_____ () In-Patient () Out-Patient

Diagnosis (include ICD-9 codes): _____

Please check off services required: () SSEPS-Uppers () SSEPS-Lowers () MEP () EMG () BAER

() Pedicle Screw-Stimulation (Triggered EMG) Other: _____

Referring Physician's Signature: _____

Patient's Name: _____ Home#: _____ Work#: _____

Address: _____

DOB: ___/___/___ SS#: ___-___-___ SEX: () MALE () FEMALE

Type of Ins: () No-Fault () Workers' Comp. () Private () Medicare

Please attach a copy of the front/back of Insurance Cards

Note: All Workers' Comp. cases need written authorization for pre-op and intra-op Neuro Diagnostic Monitoring.

Insurance Carrier: _____ Tel. _____ PreCert/Auth#: _____

Address: _____

Policy/ID#: _____ Claim#: _____ D/O/A: ___/___/___

Claims Rep: _____ Tel. _____

Policy Holder: _____ Tel. _____

Secondary Insurance Carrier: _____