BIOSERENITY
Smart Healthcare Solutions

# Certificate of Medical Necessity

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

## 1 - TYPE OF PROCEDURE ROUTINE EEG:

☐ **95816 – EEG awake and drowsy**
☐ **95819 – EEG awake and asleep**

## 2 - TYPE OF PROCEDURE AMBULATORY EEG:

☐ **Amb VIDEO EEG or** ☐ **Amb EEG ONLY** No Video
** **Both include Tech Setup/DC code: 95700**

### 2a - LEVEL OF MONITORING (VIDEO EEG)

☐ **Intermittent Monitoring**
☐ **Unmonitored**

### 2b - RECOMMENDED LENGTH OF TESTING

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

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

☐ **Other:** _____

### 2c - PHYSICIAN INTERPRETATION (optional)

☐ **Every 24 hours of recording**
☐ **At the conclusion of recording**

## CLINICAL SYMPTOMS

☐ **R55** Syncope and collapse
☐ **R56.9** Unspecified convulsions
☐ **G40.A09** Absence syndrome, not intractible, 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 (print):** _____

**Phone:** 215-957-9250

**Fax:** 215-957-9254

**Address:** 1151 Old York Rd, Ste 200, Abington, PA 19001

_____

**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**
**130 S. State Rd; Ste 202**
**Springfield, PA 19064**
**Phone: 610-543-6800**