UNITED | IONM
UNITED MEDICAL MONITORING, PC

Order Form-Please copy and fax or e-mail-See below for scheduling

Patient Name:_____ Date _____

CONTACT INFORMATION:

Scheduler Name _____

Scheduler Email _____

Scheduler Phone _____ Scheduler Fax _____

PROCEDURE:

Hospital/Facility _____

SURGEON NAME_____

Date of Procedure _____ Start Time _____ **AM / PM** Duration_____

ICD-10 Code_____

ICD-10 Description _____

Procedure Type

_____

_____

MONITORING REQUEST, PLEASE CHECK ALL BELOW THAT APPLY:

- ○ **EMG**
- ○ **SSEP (Sensory)**
- ○ **EEG**
- ○ **Motor Mapping** (Direct Cortical Stim)
- ○ **Sensory Mapping** (Phase Reversal)
- ○ **TcMEP (Motors)**
- ○ **Direct Nerve Stimulation**
- ○ **Pedicle Screw Stimulation**

OTHER_____

_____

INSURANCE / DEMOGRAPHICS • PLEASE SEND A COPY OF THE FACESHEET AND PATIENT INSURANCE CARD

PATIENT NAME_____ DOB _____

ADDRESS _____ PHONE_____

INSURER_____ INSURANCE ID #_____

GROUP NAME_____ GROUP # _____

IS PATIENT THE INSURED ? **Y N**

IF NO, PLEASE PROVIDE : INSUREDS NAME _____ INSUREDS DOB_____

Statement of Medical Necessity

Intraoperative Neuromonitoring (IONM) Services are being provided for the above named patient's surgery at my request. These services are provided for the purpose of preventing, diagnosing and/or treating an illness, injury or its associated symptoms, impairments or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice;
(2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.

Surgeon's Signature: _____ **Date** _____

SEND SCHEDULING REQUEST TO UNITED IONM P.C. By Email: scheduling@Unitedionm.com FAX: 888-289-5601
SCHEDULING HOTLINE 24/7/365: Phone: 888-279-6336
Please allow 10 minutes response time when calling outside of the hours of 8AM-5PM Eastern Time, or on weekends and holidays.

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