

REFERRAL FORM - NERVE CONDUCTION STUDY -EMG -STEROID INJECTION (NON-WORK COMP) Fax Completed form to (803) 254-2825	MIDLANDS orthopaedics & NEUROSURGERY <small>1910 Blanding Street * Columbia, SC 29201 * (803) 256-4107</small>
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Referring Physician Information	
Name:	Practice:
Contact person:	NPI:
Address:	City, State, Zip:
Phone:	Fax:

Patient Information	
Name:	Address:
SSN:	City, State, Zip:
DOB:	Female Male
Home Phone:	Work phone:

Please fax a copy of the patient's insurance cards along with this request.

Insurance Information and Authorization	
Primary:	Secondary:
Phone Number:	Phone Number:
Authorization number:	Authorization number:

Please check the requested service. All SPINE injections REQUIRE a FACILITY authorization.

	62311 – Lumbar Epidural Steroid Injection
	62310 – Cervical Epidural Steroid Injection
	64479 – Transforaminal (Cervical/Thoracic)
	64483 – Transforaminal (Lumbar/Sacral)
	20610 – Hip (laterality: _____) (no facility authorization needed)

Symptom or rule out: _____ ICD-10 (Diagnosis)
Code: _____

*****Please provide the patient with any pertinent office notes or images that may be needed to perform the requested test*****

We will contact the patient to schedule an appointment as soon as this completed form is received documenting appropriate insurance authorization.