

Insurance Card/s, Chart Notes, and Authorization Required

A	CHECK ONE BOX
<input type="checkbox"/> Consultation "Only" (CPT: 99245) <input type="checkbox"/> Evaluate & Treatment (CPT: 99245 + 99213) <input type="checkbox"/> Procedure Only (Complete Section B)	
B	PROCEDURE ONLY: (Check Region, Side, Injection & Levels)
<input type="checkbox"/> Cervical <input type="checkbox"/> Left <input type="checkbox"/> Epidural Steroid Inj. <input type="checkbox"/> Sympathetic Block <input type="checkbox"/> Stellate Ganglion Block <input type="checkbox"/> Thoracic <input type="checkbox"/> Right <input type="checkbox"/> Medial Branch Block <input type="checkbox"/> Transforaminal Nerve Block <input type="checkbox"/> Radiofrequency Ablation <input type="checkbox"/> Lumbar <input type="checkbox"/> Bilateral <input type="checkbox"/> Facet Joint Injection <input type="checkbox"/> Discography <input type="checkbox"/> Trigger Point Injections <input type="checkbox"/> Other: _____ Procedure Levels: _____	
C	REFERRING PHYSICIAN INFORMATION
Physician: _____ Contact Person: _____ Address: _____ Phone #: _____ Fax #: _____	
D	PATIENT DEMOGRAPHICS (Complete All Fields)
Patient: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: _____ Patient <input type="checkbox"/> Is <input type="checkbox"/> Is Not Ambulatory Height: _____ Weight: _____ SSN: _____ Address: _____ Home #: _____ Work #: _____ Cell #: _____ Patient's Primary Diagnosis: _____	
E	PRIMARY MEDICAL INSURANCE (Complete All Fields and send copies of card)
Carrier: _____ Plan: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> MedFin Lien Phone #: _____ ID: _____ Primary Card Holder <input type="checkbox"/> Yes <input type="checkbox"/> No Pre-cert #: _____ Effective Date: _____ Expiration Date: _____	
F	SECONDARY MEDICAL INSURANCE (Complete All Fields and send copies of card)
Carrier: _____ Plan: <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> MedFin Lien Phone #: _____ ID: _____ Primary Card Holder <input type="checkbox"/> Yes <input type="checkbox"/> No Pre-cert #: _____ Effective Date: _____ Expiration Date: _____	
G	WORKER'S COMPENSATION (Written authorization required)
WC Carrier: _____ Claim #: _____ DOI: _____ Address: _____ Employer: _____ City/State/Zip: _____ Adjuster: _____ Phone #: _____ Fax #: _____ AUTH <input type="checkbox"/> attached <input type="checkbox"/> pending	

Appointment Dr. Hendrickson Folsom
Confirmation Dr. Kelly Hunt Roseville DATE: _____ TIME: _____ AM PM