

NEUROMUSCULAR BIOPSY REGISTRATION FORM

This form must be completed and faxed before the biopsy is sent. Please fax form to (713) 798-8148. Call back number is (713) 798-7653(Kevin).

Arrival Date: _____ Muscle Biopsy () Nerve Biopsy ()
Referring Physician: _____ NPI#: _____
Phone: (____) _____ Fax: (____) _____

Patients Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: (____) _____ Work #: (____) _____
Date of Birth : _____ SSN: _____

Insurance Information

(Please attach a copy of insurance card)

Does patient have Insurance? () YES () NO
() SELF PAY-*will be billed to your institution* () HMO () PPO () POS ()
CPO () Indemnity Plan () Medicare()- _____
() Medicaid _____

Has insurance precertification or authorization been obtained? () YES () NO

(Very important we need a precert. or authorization number before specimen arrives!)

IF TEST CPT CODES NOT PRECERTIFIED, ORDERING PHYSICIAN WILL BE BILLED.

Precertification or Authorization number: _____

Name of Insured _____
Date of Birth of Insured: _____
Insured SSN/ ID#: _____
Ins. Co.: _____ Phone #: _____
Address: _____
Employer: _____ Group or Policy #: _____

Secondary Insurance

() Supplement () PPO () HMO () Indemnity Plan () POS () EPO
Insured SSN/ ID#: _____
Ins. Co.: _____ Phone #: _____
Address: _____
Employer: _____ Group or Policy #: _____