



**INTRA-OP MONITORING SERVICES**  
 76 Starbrush Circle  
 Covington, LA 70433  
 (866) 845-4595  
**FAX: (866) 845-8810**

**Fax confirmation  
 receipt to:**

**Your Fax #**

PATIENT INFORMATION: Please complete and fax this information for billing and scheduling. Your cooperation is most appreciated.

**REQUESTING DR:** \_\_\_\_\_  
**PROCEDURE DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time:** \_\_\_\_:\_\_\_\_ am pm  
**PROCEDURE TYPE:** \_\_\_\_\_

**HOSPITAL:** \_\_\_\_\_

**MODALITIES REQUESTED:** SSEP Upper\_\_Lower\_\_; EMG \_\_w/Screw  
 Test\_\_; MEP\_\_; tceMEP\_\_; Cortical Mapping\_\_; Cranial nerve\_\_; EEG\_\_;  
 ABR\_\_; Visuals\_\_

**DX: (ICD-9 CODEs)** \_\_\_\_\_  
**INPATIENT:** \_\_ **OUTPATIENT:** \_\_ **LENGTH OF SURGERY:** \_\_\_\_\_  
**PATIENT NAME:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**INSURANCE INFO: Please furnish a copy of insurance cards front/back.**

**Authorization Number if issued for surgery:** \_\_\_\_\_  
**COMPANY NAME:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**PLAN:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **POLICY#:** \_\_\_\_\_  
**GUARANTOR:** \_\_\_\_\_ **INJURY DATE:** \_\_\_\_\_  
**ADJUSTER NAME:** \_\_\_\_\_ **PH#:** \_\_\_\_\_

**TYPE OF CLAIM: WC:**\_\_ **MC:**\_\_ **MX:**\_\_ **PRIV:**\_\_ **ATTY:**\_\_ **Self:** \_\_

**I, the undersigned, request Intra-Op Monitoring Services, Inc., to be present for the above listed procedure.**

\_\_\_\_\_  
 Authorizing Surgeon