Signal Health Group
333 N. Alabama Street
Suite 218
Indianapolis, IN 46204

## Pre-Authorization Form for Neurostimulator

Patient: _____ Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Insurance Company: _____ ID#: _____

Diagnosis:

_____

_____

_____

_____

Procedure to be billed: ❑ L8679

Procedure Service Date: _____

Co-Morbidities, if applicable:

- ❑ Not Applicable
- ❑ Pregnancy
- ❑ Anti-Coagulant Therapy
- ❑ Heart Conditions/ Pace-Makers
- ❑ History of Seizures
- ❑ Haemophilia Psoriasis Vulgaris
- ❑ Other: _____

Conservative treatment:

Is there documentation in the patient's record conservative and/or medication therapies that have been tried and failed? ❑ Yes ❑ No

- ❑ Chiropractic treatment
- ❑ Medications
- ❑ Trigger Point Injections
- ❑ Physical Therapy
- ❑ Other _____

Date of Psychological Screening:

- ❑ _____

Patient has undergone proper patient education, discussion, and disclosure including an extensive discussion of the risks and benefits of this therapy.

- ❑ _____

Diagnostic Testing and Findings, as applicable:

- ❑ Not Applicable
- ❑ _____
- ❑ _____
- ❑ _____

Abnormal Symptoms/Finding:

- ❑ Not Applicable
- ❑ _____
- ❑ _____