

Signal Health Group  
3753 Howard Hughes Parkway #200  
Las Vegas, NV 89169

**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:

- |   |   |
|---|---|
| <input type="checkbox"/> Not Applicable         | <input type="checkbox"/> Heart Conditions/ Pace-Makers  |
| <input type="checkbox"/> Pregnancy              | <input type="checkbox"/> History of Seizures            |
| <input type="checkbox"/> Anti-Coagulant Therapy | <input type="checkbox"/> Haemophilia Psoriasis Vulgaris |
| <input type="checkbox"/> Other: _____           |   |

Conservative treatment:

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

- |   |   |
|---|---|
| <input type="checkbox"/> Chiropractic treatment | <input type="checkbox"/> Trigger Point Injections |
| <input type="checkbox"/> Medications            | <input type="checkbox"/> Physical Therapy         |
| <input type="checkbox"/> 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
- \_\_\_\_\_
- \_\_\_\_\_