REGIONAL BRAIN AND SPINE

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A Practice of Micro-Neurosurgery

Billing Authorization Form

Please check the type of visit authorized for

☐ ***Independent Medical Examination*** *-one time evaluation with rapid reporting that includes a complete neurological exam and a review of diagnostic testing, pertinent medical records, and pertinent diagnostic imaging studies. This report includes a diagnostic impression with reference to causation and whether maximum medical improvement (MMI) has been achieved. Further, it includes recommendations regarding any additional, necessary diagnostic studies and/or whether any additional treatment is likely to be beneficial. IME records over one inch in height will necessitate an additional charge for review.* ***IME fees are non-negotiable and not subject to any state fee schedule or contract reduction. $250 cancellation or no show fee.***

☐ ***Evaluation and Treatment*** *-consultation including review of new diagnostic imaging studies, coordination of care, and ongoing treatment.*

☐ ***One Time Visit*** *-consultation that includes a complete neurological exam, review of diagnostic studies, formulation of diagnostic impression, and treatment recommendations.* ***(This is not applicable if the patient has been released at MMI or had a previous neurosurgical or orthopedic spine opinion.)***

Please send all pertinent prior medical records to us, along with this completed form. Should you have any specific questions to be addressed at the visit, please include them with this information.

Patient must hand carry all films to scheduled appointment.

Fax completed form to 573-339-9709 prior to the scheduled appointment. If you have billing questions please contact us at 573-332-7746 (SPINE)

Please provide the information below to facilitate the billing and payment process.

Please check one: ☐ Mail ☐ Fax

Charges should be sent to:

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State of Jurisdiction: ____________

Claim #: ______________________

Phone: _______________________

Fax: _________________________

E-mail: _______________________

Date of Injury: ______________

Nurse Case Manager:

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____

____

State of Jurisdiction: ____________

Claim #: ______________________

Phone: _______________________

Fax: _________________________

E-mail: _______________________

Location of Injury: ☐ Back ☐ Neck ☐ Head ☐ Hands ☐ Other

I authorize payment in full for services provided to the above named patient at Regional Brain and Spine, unless otherwise contracted. (We are contracted with Comp Logic, Comp Results, Corvel, Healthlink, and Three Rivers. Also accepting the fee schedule for the States of Illinois and Arkansas, not combined with any other contract.)

Our clinic does not accept usual and customary pricing without prior signed authorization from the billing supervisor.

______________________________ ______________________________

Authorizing Agent   Date   Printed name of Agent   Date