DT18123

NON INVASIVE CARDIOLOGY REQUEST FORM

Children's Healthcare of Atlanta
The Sibley Heart Center

Egleston Campus
1405 Clifton Road, N.E.
Atlanta, GA 30322-1101
Office (404) 785-6476 Fax (404) 785-6021

Patient Name:_____

Date of Birth:_____

MRN:_____

Account/HAR#:_____

Patient Identification

Parent/Guardian's Name:_____Phone:_____Cell/Work: _____
Address: _____City: _____State:____ Zip: _____
Guarantor Name:_____ Guarantor DOB: _____Guarantor Sex: □ M □ F
Guarantor Phone:_____Relationship to Patient:_____
Insurance/Medicaid Plan: _____ Policy & Group #:_____
Please note: Outpatients that require prior authorization must have authorization on all CPT codes listed for that exam.
Authorization #: _____ CPT: _____ ☑ if available & legible, please also fax copy of Insurance card

ECHOCARDIOGRAMS

_ Echo Complete (Congenital)
CPT 93303, 93320, 93325
_ Echo Complete (Non-Congenital)
CPT 93306
_Echo 2D w/o Spec/Color Flow Dopp
CPT 93307
_ Echo Limited (Congenital)
CPT 93304, 93321, 93325
__ Echo Limited (Non-Congenital)
CPT 93308, 93321, 93325
__ Fetal Complete (Congenital)
CPT 76825, 76827, 93325
__ Fetal Limited (Congenital)
CPT 76826, 76827, 93325

ELECTROCARDIOGRAMS

_ Electrocardiogram
CPT 93000
_ Rhythm Strip
CPT 93041
_Holter Monitor
CPT 93225, 93226
_ Transtelephonic Monitor
CPT 93012

PACEMAKER ANALYSIS

__ Pacemaker Single
CPT 93288
__ Pacemaker Dual CPT 93288

OTHER

_Six Minute Walk Test CPT 94620
_ Vascular Exam (**RESEARCH ONLY**)

_____
_____

Diagnostic questions: Each individual procedure code ordered must include a reason for that procedure.

_____
_____

Special requests or instructions? Sedation: ___ Yes ____ No Portable: ___ Yes ___ No (Egleston campus)

_____
_____

Procedure completed (date, time, Initial) _____

Ordering Physician's Signature (REQUIRED) _____
Print MD Name: _____
Date Signed (REQUIRED): _____

Office Contact: _____
Practice Name: _____
Backline Phone: _____
Fax: _____

OFFICE USE ONLY
DATE AND TIME OF APPOINTMENT: _____ SCHEDULED BY: _____