VERSA CARDIO
CARDIAC SERVICES
1-855-329-5794

Fax copy of patient face sheet with this form.
Fax (855) 399-5796

Hookup Date: _____ Return Date: _____

obile Cardiac Telemetry Order Form

Recorder Serial# (Last 4 Numbers): _____

'atient Name: _____

'atient Address: _____

ity: _____ State: _____ Zip: _____

Date of Birth: _____ Male ◯ Female ◯

SSN#: _____

Telephone#: _____

nsurance Info

Insurance Name: _____

Ins Phone: _____

Member ID#: _____ Group ID#: _____

Physician Info

Physician Name: _____

Physician Phone: _____

ICD9 Codes

- ☐ 427.61 Supra Ventricular Premature Beats
- ☐ **785.1 Palpitations** / 426.9 (Conduction Disorder unspecified)
- ☐ **780.2 Syncopy and Collapse / 780.4 Dizziness**
- ☐ 427.0/1 Paroxysmal Supraventricular/Ventricular Tachycardia
- ☐ **785.0 Tachycardia Unspecified**
- ☐ 427.31 Atrial Fib. / 427.81 Sinoatrial Node Dysfunction
- ☐ 427.32 Atrial Flutter
- ☐ **427.9 Cardiac Dys. Unsp.** / 426.89 Other Conduction Dis.
- ☐ 426.10 - 426.13 Atrioventricular Block Unspecified
- ☐ 427.81 Sinoatrial Node Dysfunction
- ☐ 426.6 Other Heart Block / Blocks

☐ Other

Billing Codes

Medicare Billing Codes

CPT 93228 (Mobile Cardiac Telemetry)

☐ CPT 93225, 93227 (Arrhythmia Totals are detected and billed on the first day of monitoring)

Private Insurance Billing Codes

CPT 93270, 93272 (93228*) (Telemetry Monitoring)

☐ CPT 93225, 93227, (Arrhythmia Totals)

Medical Necessity

ⓘ Statement of Medical Necessity

The requested service(s) are medically indicated and necessary to the health of the patient. I understand that this procedure is mobile cardiac telemetry monitoring, providing a signicantly higher yield for capturing cardiac arrhythmias associated with the indications and diagnosis of this patient. I decide the length and duration of the monitoring. I am responsible for my own billing procedures.

Physician Signature _____

Patient Signature

ⓘ Patient Signature

I hereby authorize the cardiac lab to inquire, appeal, and receive all information on my behalf regarding the procedure(s) on this order. I hereby authorize the release of any medical accounting information necessary to process my medical insurance claim. I hereby authorize I understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information has been made prior to receipt of the revocation. I also authorize payment of medical benefits to the above provider, its intermediaries, or carriers on any unassigned and assigned third party payor medical insurance claims. I further permit copies of this authorization to be used in place of the original. I understand I am ultimately responsible for the cost of the testing.

Patient Signature _____