Life Support, Inc.

Fax form to 800-535-1706

Call event baseline to **800-659-8151**

Cardiac Event Enrollment Form

OVERNIGHT HOME ENROLLEMENT

Patient: _____ **DOB:** _____

LAST FIRST MI

SSN: _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Work Phone:** _____

Cardiovascular Medications: _____ **Emer. Phone:** _____

Indications for Monitoring

* At least one of these indications required to meet insurance guidelines for event monitoring

ICD-9	Description	ICD-9	Description	ICD-9	Description
427.32	Atrial Flutter	**780.40**	**Lightheadedness**	427.10	Paroxysmal Ventricular Tach
427.31	Atrial Fibrillation	425.10	Hypertrophic Cardiomyopathy	427.60	Premature beats, unspecified
427.81	Bradycardia	427.80	Paroxysmal SVT	**780.20**	**Syncope***
427.90	Cardiac Arrhythmia	996.01	Mechanical complication from	427.81	Tachy/Brady Syndrome
786.50	**Chest Pain***		Cardiac Pacemaker	435.90	Transient Ischemic Episodes
780.40	**Dizziness***	**785.10**	**Palpitations***	995.20	Unspec. adverse drug effect
788.09	Dyspnea			427.41	Ventricular fibrillation

CLINIC NAME _____

ORDERING PHYSICIAN _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____ **FAX** _____

I certify that this test is medically necessary for this patient.

Rx

_____Please monitor the patient with cardiac event monitoring for 30 days Circle Monitor Type Looping/Non-Looping

Monitor SN _____

Please Complete for Medicare Patients

(Copies of cards required)

Medicare:	ID #	Group	Ph #
Secondary:	ID #	Group	Ph #
Policy Holder:	Relationship:	DOB	Employer:

Assignment of Benefits/Statement of Responsibility for Equipment

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment t below. I recognize and accept responsibility for any balance remaining after payment of such benefits. In addition, I accept responsibility for the cardiac event monitor and agree to return it in normal working condition. I will promptly return the monitor and supplies upon completion of my monitoring period. Failure to do so will result in my being billed for the cost of the monitor.

Signed: _____ Date: _____

Relation to insured: _____ Phone: _____