

Time: _____
(request in box)

**University of Rochester Eye Institute
Ophthalmic Testing Request/Billing Form**

Technical Testing Request form (3-11-2004).doc



601 Elmwood Ave – Box #659-Rochester, NY 14642

Appointments call: (585) 275-3446 / FAX: (585) 506-4185

Patient Name: _____
DOB: _____
Referring Doctor: _____
Place of Referral: _____

Diagnosis: _____
Date of Test: _____
 Scheduled or Unscheduled/same day
DO NOT COVER DR'S NAME WITH LABEL

Test (alphabetical)		1 eye (5161)	2 eyes (5161)	Test (alphabetical)		1 eye (5161)	2 eyes (5161)
100-Hue (color test) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0408	0409	Humphrey VF - 24-2 SITA/Size III <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0432	0433
A-Scan** <input type="checkbox"/> Both eyes done Mark Surgical eye: <input type="checkbox"/> OD <input type="checkbox"/> OS		0300	0300	Humphrey VF, SWAP (Blue, yellow) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0432	0433
B-Scan (make sure tech avail when sch) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0301	0301	Humphrey VF, Other: _____ <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0432	0433
Contrast Sensitivity <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0400	0400	IOL Master(Biometry)** <input type="checkbox"/> Both eyes done Mark Surgical eye: <input type="checkbox"/> OD <input type="checkbox"/> OS		0424	0424
D-15 (color test) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0408	0409	Laser Interferometry (dilation required) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0416	0417
D-Curve <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0402	0403	Orbscan-topography <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0401	0401
<input type="checkbox"/> EOG <input type="checkbox"/> ERG <input type="checkbox"/> MERG		Booked thru Dr. Chung's office (273-3937) & interpreted by Dr. Chung		Pachymetry <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0419	0420
		0404	0405	PAM (dilation required) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0418	0418
		0406	0407	Spectral Microscopy (endothelial cell count) <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0429	0430
		0406	0407	Teller Acuity <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0431	0431
Goldmann VF <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0432	0433				
HRT <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> Both eyes		0412	0413				

** IOL master and A-Scan cannot both be billed, if both done, bill for A-Scan only. ** Office staff: please check for previous A-Scans on pseudophakic patients to eliminate unnecessary repeating of test prior to ordering of test. All testing to be done require a request form prior to doing a test.

Any Special Instructions: _____ **Time pt. Dilated:** _____

Work-Up SC/CC _____ W _____ MR _____
SC/CC _____

PAM results: OD: _____ OS: _____
LI results: OD H: _____ OD V: _____
OS H: _____ OS V: _____

Date of Test(s): _____ : _____ OD OS Both eyes
Tests : _____ OD OS Both eyes : _____ OD OS Both eyes
If no charge visit, please list reason here:(educational, study, repeat, etc): _____

L. Addams D. Castillo W. Fischer G. Grant J. Howell M. Keim T. Long
 B. McElwain M.Middeker T. Richard T. Schaefer T. Smith K. Steinmetz _____

<input type="checkbox"/> ABMD 371.52	<input type="checkbox"/> CME 362.83	<input type="checkbox"/> Headaches 784.0	<input type="checkbox"/> Plaquenil Tx 362.55
<input type="checkbox"/> AION 377.41	<input type="checkbox"/> Cupping of disc/GL 377.14	<input type="checkbox"/> Irregular Astig. 367.22	<input type="checkbox"/> Post. Capsul Opac. 366.53
<input type="checkbox"/> ARMD 362.50	<input type="checkbox"/> Diabetic Retinopathy 362.01	<input type="checkbox"/> Keratoconus 371.60	<input type="checkbox"/> Pseudotumor Cer. 348.2
<input type="checkbox"/> Brain Tumor 239.6	<input type="checkbox"/> Fuch's endothe. Dystro. 371.57	<input type="checkbox"/> Keratopathy 371.40	<input type="checkbox"/> Pterygium 372.40
<input type="checkbox"/> BDR 362.01	<input type="checkbox"/> Glaucoma, non specific 365.9	<input type="checkbox"/> Mac Degen(ARMD) 362.50	<input type="checkbox"/> Ptosis (eyelid) 374.30
<input type="checkbox"/> BRVO 362.36	<input type="checkbox"/> Glaucoma suspect 365.00	<input type="checkbox"/> Macular Edema 362.83	<input type="checkbox"/> Retinitis Pigment. 362.74
<input type="checkbox"/> Cataract 366.9	<input type="checkbox"/> Glaucoma, COAG 365.11	<input type="checkbox"/> Maculopathy-toxic 362.55	<input type="checkbox"/> S/P PK w/complication 996.51
<input type="checkbox"/> CRAO 362.31	<input type="checkbox"/> GI - Cupping of Discs 377.14	<input type="checkbox"/> Optic Atrophy 377.10	<input type="checkbox"/> Stroke (s/p CVA) 436
<input type="checkbox"/> Color Vision Def. 368.59	<input type="checkbox"/> Glaucoma, Narrow < 365.02	<input type="checkbox"/> Optic Neuritis 377.30	<input type="checkbox"/> SNV 362.16
<input type="checkbox"/> Corneal Graft Rej. 996.51	<input type="checkbox"/> GI - Ocular HTN 365.04	<input type="checkbox"/> Optic Neuropathy 377.39	<input type="checkbox"/> Uveitis 364.3
<input type="checkbox"/> Corneal Edema 371.20	<input type="checkbox"/> Glaucoma, POAG 365.11	<input type="checkbox"/> Papilledema 377.00	<input type="checkbox"/> Visual field Defect 368.40
<input type="checkbox"/> Corneal Ulcer 370.0	<input type="checkbox"/> Graves 242.0	<input type="checkbox"/> Pituitary Tumor 239.7	<input type="checkbox"/> Vision Loss 369.9
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pt location: Cornea waiting rm Retina/Neuro waiting rm Neuro dilating Retina Dilating Clinic waiting rm Exam room #: _____
When test done: Pt to see ref doctor Pt can check-out Other: _____