

Order Form – Anorectal Manometry & Balloon Expulsion Testing

Referring Provider Information

Provider Name: _____ Practice: _____

Phone: _____ Fax: _____

Contact Person / Nurse: _____ Email (optional): _____

Patient Information

Patient Name: _____ DOB: _____ Phone: _____

Insurance: _____ Insurance ID: _____ Group #: _____

Requested Service

- Testing Only (results faxed back to referring provider)
 Referral for Evaluation & Management with Testing

ICD-10 Diagnoses (check all that apply)

(Common indications – please verify payer-specific requirements)

- K59.00 – Constipation, unspecified
 K59.01 – Slow transit constipation
 K59.02 – Outlet dysfunction constipation
 K62.89 – Other specified diseases of anus and rectum
 K59.4 – Anal spasm
 R15.0 – Incomplete defecation
 R15.9 – Fecal incontinence, unspecified
 R15.2 – Fecal urgency
 Other: _____

Authorization

- Authorization obtained by referring provider – Auth #: _____
 Please obtain authorization on our behalf (attach insurance info & demographics)

Additional Information

- Please fax **most recent clinic notes, relevant imaging, and procedure reports.**
- Comments / special instructions:

Referring Provider Signature

Signature: _____ Date: _____

Printed Name: _____