Life Support, Inc.

Fax form to **800-535-1706**
Call with questions to **800-659-8151**

Holter Enrollment Form

HOOK-UP TECH NAME:______________
HOLTER SN:________________________

Patient: ____
LAST FIRST MI
Address:____
City:_________________ **State:**_________ **Zip:**__________
Cardiovascular Medications:_______________________________

DOB:_________________________
SSN:_________________________
Home Phone:__________________
Work Phone:__________________
Emer. Phone:__________________

Indications for Monitoring
Please mark ALL that apply

ICD-9	Description	ICD-9	Description	ICD-9	Description
427.32	Atrial Flutter	427.41	Ventricular Fibrillation	427.1	Paroxysmal Ventricular Tach
427.31	Atrial Fibrillation	425.10	Hypertrophic Cardiomyopathy	785.1	Palpitations
427.81	Bradycardia	427.80	Paroxysmal SVT	780.20	Syncope
427.9	Cardiac Dysrhythmia, unspec	780.4	Dizziness	427.81	Tachy/Brady Syndrome
786.50	Chest Pain				

CLINIC NAME_______________________________________
ORDERING PHYSICIAN________________________________
ADDRESS____
CITY_________________ **STATE**________________ **ZIP**__________
PHONE_____________________ **FAX**_______________________

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

Rx (check)

___________________ **Start Date** _____________ **Start Time**
___________________ **Stop Date** _____________ **Stop Time**

_______ **24 hours** _______ **2 Channel** **ICD?** _______ Yes _______ No
_______ **48 hours** _______ **3 Channel** **Pacemaker?** _______ Yes _______ No
_______ **72 hours**

Insurance Information
(Copies of insurance cards **required** for Medicare patients)

Primary: ______________ 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 monitor and agree to return it in normal working condition. I will promptly return the monitor upon completion of my monitoring period. Failure to do so will result in my being billed for the cost of the monitor.

Patient Signature:____ Date:________________
____

Relation to patient:____ Phone:____________________