OSF HEALTHCARE
Illinois Neurological Institute

Date: _____

*****INSURANCE AUTHORIZATION REQUIRED PRIOR TO SCHEDULING*****

Request for Service
Phone: 877-464-6670 ● Fax: 877-464-6806 ● www.ini.org

◯ **Consultation** ◯ **Test +/or Treatment** ◯ **Consultation, Test and Initiate Treatment**
Reason for Request/Diagnosis: _____
Urgent Request: ◯ **Yes** ◯ **No If Yes, reason** _____
Requesting Provider Signature:

**** Please check the requested facility/service and fax completed form with records to 877-464-6806**

☐ **INI Neurosurgery**
☐ **Spine Center**
☐ **INI Gamma Knife Clinic – SFMC**
☐ **INI Physical Medicine & Rehabilitation**
☐ **INI Carotid Clinic**
☐ **INI Interventional Radiology**
☐ **Neuro-Ophthalmology**
☐ **Neuro-Vestibular Clinic (Vertigo)**
☐ **Audiology**

☐ **OSF Sleep – Fax: (309)655-6967**

Will patient need an interpreter?
Yes: ☐ **Type:** _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Primary Insurance: _____ ID: _____

INSURANCE AUTHORIZATION # _____

Is this a Worker's Compensation Case? AUTHORIZATION #_____

Requesting Provider: (First/Last Name)_____

Address _____ City _____ Zip _____

Contact Person: _____ Phone ( ) _____ Fax ( ) _____

Primary Care Physician: _____

Please fax the following with the completed request form to 877-464-6806:

- Any relevant office notes and a pertinent summary/problem list
- All relevant testing

Please circle the type of testing completed and the facility where it was performed

X-ray CT MRI EEG EMG/NCV CT-Myelogram Doppler studies Angiogram -Select Testing-

OSF Carle Methodist Great Plains Pekin Graham IVCH St. Margaret Carle Bromenn -Select Facility-