ILLINOIS eye CENTER
Your Vision Empowered

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REFERRING ORDER FOR TESTING ONLY

Fax completed forms to Illinois Eye Center (309)243-7936.
Representatives may be reached via phone at (309)243-2400.
If available to your office, please direct email the patient's CCD to Direct@illinoisEyeCenterPeoriaIL.CompulinkDirect.com.

PATIENT INFORMATION

Last_____

First_____ MI_____

Address_____

_____

City/St/Zip_____

Phone (home)_____

Phone (cell)_____

Date of Birth _____/_____/_____

Account Responsible _____

Primary Insurance_____

ID_____ Group_____

(attach front and back copy of all insurance cards)

ORDERING PROVIDER INFORMATION

Physician Name_____

NPI_____

Practice Name_____

Address_____

City/St/Zip_____

Phone_____

Fax_____

Testing Order:

- ☐ Visual Field Goldmann Perimetry 92082
- ☐ Visual Field Automated Perimetry 92083
- ☐ Image Scan, NFL (OCT) 92133
- ☐ Image Scan, Macula (OCT) 92134
- ☐ Ultrasound ASCAN 76519
- ☐ Ultrasound BSCAN 76512
- ☐ IOL Master 92136
- ☐ Corneal Topography 92025

Eye:

☐ Right Eye ☐ Left Eye ☐ Right and Left Eyes

Interpretation:

- ☐ with interpretation
- ☐ without interpretation

Diagnosis (ICD10 codes):

1_____ 2_____

3_____ 4_____

Ordering Provider Signature and Date:

_____ _____/_____/_____

SIGNATURE DATE

THIS BOX TO BE COMPLETED BY ILLINOIS EYE CENTER

Appointment Date: _____/_____/_____

Appointment Time: _____

Doctor: _____

Location: Peoria Washington

IEC Account : _____