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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 : _____

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