Stony Brook Medicine

Medicare Physician Order Form

Physician to complete in full, sign and date

Patient Name: _____ DOB:_____

Referring MD: _____

Test Ordered _____

Please circle

Hearing loss	Yes	No
	Right/left/both	
	Symmetrical/asymmetrical	
	Recent onset or progressive/long standing	
Vertigo	Yes	No
	Recent onset or progressive/long standing	
Tinnitus	Yes	No
	Recent onset or progressive/long standing	

Is test ordered :

To evaluate the cause of the hearing, tinnitus or balance concern?	Yes	No
An initial evaluation or a suspected change in hearing, tinnitus or balance?	Yes	No
To determine the need or effect of medical or surgical treatment?	Yes	No

Medical diagnosis being considered _____

_____ _____

Physician Signature Date

Office Use Only

___ Billable to Medicare ____ Not Billable to Medicare _____

Encounter # _____