## UCI Health

## Fax completed form with supporting documents to 855-813-0240

Please Include: copy of insurance card, demographics, and pertinent clinical notes. \*\* Failure to include this may cause a delay in processing \*\*

Phone: Fax:
Referral Coordinator:
Date of Birth (MM/DD/YY): Sex: □ M □ F
City: State: ZIP:
Second Contact Phone:
ICD-10:
<ul> <li>OTHER (all include anesthesia code)</li> <li>Colonoscopy (45378, 45380, 45385, 00812)</li> <li>Colonoscopy &amp; Dilation (45386, 00811)</li> <li>Colonoscopy &amp; Stent (45378, 45380, 45387, 00811)</li> <li>EMR (lower) (45385, 45381, 45382, 00811)</li> <li>ESD (lower) (45385, 45381, 45382, 00811)</li> <li>EGD &amp; Biopsy (43239, 00731)</li> </ul>
<ul> <li>EGD &amp; Biopsy (43239, 60731)</li> <li>EGD &amp; Cellvizio (43239, 43206, 43252,00731)</li> <li>EGD &amp; Dilation (43249, 00731)</li> </ul>
<ul> <li>EGD &amp; Endoflip ( 91040, 43239, 00731)</li> <li>EGD &amp; Stent (43266, 00731)</li> <li>EMR (upper) (43236, 43239, 43251, 43254, 43255, 00731)</li> <li>ESD (upper) (45385, 35381, 45382, 00811)</li> <li>Endoscopy &amp; RF Ablation (43229, 43270, 99070, 00731) for Cryoablation use (43229, 43270, C2618, 00731)</li> </ul>