Small Bowel Capsule Endoscopy
CPT® code 91110

Patient Name: _____
Insurance ID or Group Number: _____
Policy Holder Name: _____

Reason/Indication:

- ☐ **1. Obscure gastrointestinal bleeding**
- ☐ **2. Suspected Crohn's disease**
- ☐ **3. Known Crohn's disease**
- ☐ **4. Celiac disease**
- ☐ **5. Suspected tumor**

Circle below ALL symptoms and indications that apply:

787.0 Nausea & Vomiting	**280.9 Iron deficiency anemia, unspecified**
787.03 Vomiting alone	**280.0 Iron deficiency anemia 2ndary to blood loss (Chronic)**
787.02 Nausea alone	**787.91 Diarrhea**
790.1 Elevated ESR or CRP.	**783.21 Significant weight loss**
578.1 Blood in stool, melena.	**789.00 Abdominal pain, unspecified**
792.1 Non specific abnormal findings in stool	**789.01 Abdominal pain, RUQ**
578.9 Hemorrhage of GI tract, unspecified	**789.02 Abdominal pain, LUR**
555.1 Regional enteritis large intestine	**789.03 Abdominal pain, RLQ**
564.1 Irritable bowel syndrome	**789.04 Abdominal pain, LLR**

Others not listed: _____

Previous Diagnostic Tests Performed

Date of last EGD: _____ Results: _____
If not done explain why? _____
(i.e. EGD does not reach the small intestine to evaluate)
Date of last Colonoscopy: _____ Results: _____
If not done explain why? _____
(i.e. Colonoscopy does not evaluate the small intestine)
Date of last Small bowel Follow Through: _____ Results: _____
If not done explain why: _____
(i.e. Has low diagnostic yield)
Other diagnostic tests and dates: _____

[Please complete this section if patient is diagnosed with Iron Deficiency Anemia]
Initial Hemoglobin level: _____ Date of lab test:
Hematocrit level: _____
Is patient on any iron supplements? **YES** or **NO** if yes, how long? _____
Has patient had a blood transfusion? **YES** or **NO** if yes, how many & when? _____

Other pertinent medical history: _____

(Insert Practice Name, address & phone number, Tax ID # and / or Provider ID#)
MD Signature

Type of use:
Prior Authorization, Letter of Medical Necessity, Billing or claims reporting