

**THE SPINE COUNCIL, INC**  
*Providing Authoritative Guidance on Spine Coding and Reimbursement*

**CASE REGISTRATION FORM**

Name of Physician and/or Contact Person:	
Telephone:	
Email Address:	
Claimant:	
Total Amount of Claim \$:	
Ruling Fee:	Case Categorization:
Nature of Dispute Claimant:	Nature of Dispute Opposition:
Insurance Company:	
Type of Claim: <input type="radio"/> Workers' Compensation <input type="radio"/> Auto <input type="radio"/> Commercial <input type="radio"/> Medicare <input type="radio"/> Medicare Replacement	Documents Submitted: <input type="radio"/> Operative Report <input type="radio"/> HCFA Codes Submitted <input type="radio"/> EOBs <input type="radio"/> Appeals Letters <input type="radio"/> Insurance Correspondence
<u>Reviewers Selected:</u>	

Please complete, and submit the form via fax at (516) 213.1340, e-mail at [contact@thespinecouncil.com](mailto:contact@thespinecouncil.com) or regular mail at: 200 Old Country Road, Suite 470, Mineola, NY 11501

***For Office Use Only***

Case Number _____
Acceptance Date ____/____/____
Ruling Date ____/____/____

*The Spine Council Inc. seeks to provide the spinal community, physicians and payers alike, with expert, fair and unbiased analysis and education in all aspects of spinal procedural coding and reimbursement*

**200 Old Country Road, Suite 470, Mineola, New York 11501 Telephone 516.248.4488 Facsimile 516.213.1340  
 www.thespinecouncil.com e-mail [contact@thespinecouncil.com](mailto:contact@thespinecouncil.com)**