Palisade Surgery Center, LLC

SURGICAL SCHEDULING

Patient Name: _____ MR#: _____

Birth Date: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City/State: _____ Zip Code: _____

Physician Name: _____ Contact Name & Phone: _____ Assistant Surgeon? Y / N Physician Name: _____

Surgery Date Requested: _____ First Case Start Time: _____ Case To Follow Start Time: _____

Approximate Surgery Duration HR(s): _____ Anesthesia Type: (Circle One) General IV Sedation Local

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Procedure Description: _____

CPT Codes: 1. _____ ICD9 Codes (Diagnosis): 1. _____

2. _____ 2. _____

3. _____ 3. _____

4. _____ 4. _____

AUTH#: _____ Authorized By: _____

NOTE: PLEASE PROVIDE A COPY OF THE AUTH LETTER. CHECK HERE IF NO AUTH IS REQUIRED: ☐

BENEFITS: (Circle One) MAJOR MED WORKCOMP PIP/NO FAULT

Insurance Company Name: _____ Address/Phone: _____

Insured Name: _____ ID#: _____

Employer: _____ Injury Date: _____

Claim Adjuster: _____ Claim#: _____

Contact Info: _____

Accredited by The Joint Commission

CMS Centers for Medicare & Medicaid Services

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