

SURGERY
PHYSICIAN SURGERY SCHEDULING/BILLING WORKSHEET

ASSIGNED SURGERY DATE: _____

PATIENT NAME _____ DOB ___ / ___ / ___ MRN _____

Telephone Number Home _____ Work/alt number _____

Cell Number: _____ Fax _____

Email address: _____

SURGEON: _____ CO-SURGEON/ASST _____

AMBULATORY ___ SDS/IN-PAT ___ IN-HOUSE _____

L.O.S. ___ HOURS ___ BLOOD ___ AUTOLOGOUS ___ CELL SAVER ___ SSEP ___

LOCATION: Hospital #1 ___ Hospital #2 ___ ASC ___ OTHER: _____

ANESTHESIA: GENERAL ___ REGIONAL ___ MAC ___ OTHER ___

CPT CODE/DESCRIPTION (S)
(PLEASE WRITE THE DESCRIPTION)

MODIFIER

ICD-9CM CODE (s)
(PLEASE WRITE THE DESCRIPTION)

RVUs

1. _____

2. _____

3. _____

4. _____

DOCTOR SIGNATURE: _____ (sign to approve CPT codes for billing)

SPECIAL EQUIPMENT: -

PRE-OPERATIVE REQUIREMENTS

Medical Clearance by: Internist ___ Cardiologist ___ Anesthesia ___ Standard PAT ___

LatexFreeRoom ___ Other _____

INSURANCE INFO

PRECERT# _____ TALKED WITH: _____

Name of person precertifying: _____ Date precertification complete: _____