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AMBULATORY SURGERY CENTER

Surgery Date 01/01/2024 **Time**

Surgeon NAME, MD

Patient FIRST LAST **DOB** 01.01.19**

SS# xxx-xx-**** **Height** cm **Weight** kg

Address Text

Home Phone ***-***-**** **Work Phone** **Cell**

*************CODES ARE NEEDED ON ALL SURGERY REQUEST*************

Diagnosis Code & Description Text

CPT Procedure Code & Description Text

Needs:

C-Arm **Video** **Implant** **Garment** **23Hr Stay**

Special Instruments Text

(CIRCLE ONE)

Anesthesia: __x__ **General** ____ **Mac** ___ **Local** ___ **Block Axillary or Bier**

Primary Insurance Text **Phone** Text

Policy # Text **Group #** Text

Precert # **Contact**

Secondary Insurance **Phone**

Policy # **Group #**

Precert # **Contact**

PLEASE FAX A COPY OF THE PATIENT'S INSURANCE CARD

504-897-8886