# WESTON OUTPATIENT SURGICAL CENTER

## SURGERY SCHEDULING REQUEST FORM

**Attn: Clarisse Gonzalez**
**Phone: 954-703-3052**
**Fax: 954-703-3152**

**Today's Date_____** **Form SSRF - 2**

Patient Name_____ DOB_____ Sex ____ SS # _____

Address_____

Home Ph #_____ Cell Ph # _____ Work Ph #_____ Ext._____

**Primary Insurance / Payor**

□ HMO (in-network only) - □ HMO/POS - □ PPO - □ EPO (in-network only) - □ EPO/POS - □ Commercial - □ Self Pay

□ Medicare (regular) - □ Medicare HMO – □ Medicaid - □ Worker's Comp - □ Auto Accident PIP - □ Auto Accident Legal

Date of Accident or Illness: ____/____/_____ -- Front and Back Copy of Insurance Cards Submitted: □ Yes □ No

Insurance Carrier _____ Phone #_____

Insurance Address _____

Insured's Name _____ Patient Relationship to Insured: □ Self □ Spouse □ Child/Dependant

Insured's Employer _____ Insured Emp's Ph #_____

Insured's SS #_____ ID # _____ Group #_____ W/C or Auto Claim # _____

Pre-Certification #_____ Contact Name_____ Phone # _____

Secondary Insurance Carrier _____ Ph # _____ ID # _____ Grp # _____

**Surgeon / Surgery Information**

**Surgeon Name** _____ Contact _____ Ph #_____Fax #_____

**Date of Surgery** _____/_____/_____ **Time of Surgery**_____ **Length**_____ **Type of Anesthesia**_____

**Primary Diagnosis** _____ ICD 9 code_____

**Secondary Diagnosis** _____ ICD 9 code _____

**Primary Procedure** _____ CPT code_____

**Secondary Procedure** _____ CPT code _____

CONSENT TO READ: _____

_____ □ Right □ Left □ Bilateral □ NA

**Special Equipment / Other Needs**_____

_____

Pre Op Labs to be done: □ CBC □ SMA □ UA □ SERUM PREG □ PT □ PTT □ OTHER_____

Pre-Op Labs being done at _____ Phone #_____

Medical Clearance by Dr. _____ Phone #_____

******Please Fax Physician Orders and Front & Back Copy of Primary and Secondary Insurance Card(s) ******

**Response from WOSC:**

Initial and Date: _____ □ **Surgery Confirmed for Requested Date and Time**

_____ □ **Surgery Scheduled/Rescheduled for Date: _____ Time: _____**

**WESTON OUTPATIENT SURGICAL CENTER**
**INSURANCE VERIFICATION FORM**

## Primary Insurance

Carrier Name:_____ Insured's Name:_____ SS#_____

Relationship: □Self □Spouse □Child/Dependant

Ins Address:_____

Ins Ph#:_____ ID#: _____ Grp#:_____

Insured's Employer:_____ Insured's Emp Ph#_____

Referral /Authorization #:_____

## Secondary

Carrier Name: _____ ID#_____ Grp#_____

## Worker's Comp

Patient Employer Name_____ Phone#_____

Insurance Carrier Name_____ Phone#_____

Address_____

Case Mgr. Name_____ Phone#_____ Ext._____

Date of Accident_____/_____/_____ Claim#_____ Auth.#_____

Any additional information, i.e. atty _____

## Auto Accident

Insurance Carrier Name_____ Phone#_____

Address_____

Policy Holder Name_____ Relation to Policy Holder_____

Adjuster Name_____ Phone#_____ Ext._____

Claim#_____ Date of Accident ____/____/____ Auth#_____

Attorney Name _____ Phone#_____

Address_____