

WESTON OUTPATIENT SURGICAL CENTER  
**SURGERY SCHEDULING REQUEST FORM**

Attn: Mara Mongello  
954-389-8885 or 954-389-2446 ext 201  
Fax: 954-389-6364

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: \_\_\_\_\_