

Surgical Precertification

Patient: _____ **Surgery Date:** ____/____/____

Anesthesia: MAC Gen Local w/Pop. Pain Pump **Length:** _____Min Hours

Location: BNHC ECH EMP Joe/James Brom. **Position:** Supine Prone Lateral

Surgical Procedures: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Special Needs: Fluroscopy Mini/Small/Large Frag. Cannulated/Vilex
 Pain pump Orthosorb Pins Graftjacket/Pegasus

Other: _____

Bring: ___Short Boot ___Tall Boot ___Aircast ___Surgical Shoe

Date Called: ____/____/____ Contact Name: _____

Coverage in Effect? Yes No

Deductible? Yes No Reset Date: ____/____/____

Amount: \$ _____ Amount Met to Date: \$ _____

Copay/Coinsurance? Yes No Amount? _____

Policy Limits? _____

H&P by Dr. _____ Scheduled: ____/____/____

Consent Done? Yes No

Faxed

Faxed

Schedule ____/____/____

Labs ____/____/____

H&P ____/____/____

History ____/____/____

Post-Op Call ____/____/____

Notes: _____

Initials: _____