



LAGUNA HILLS
SURGERY CENTER

Surgery Scheduling Form

Please fax this form

Phone 949 855-0562 Fax 949 855-0564

Surgery Date / Time: _____ Surgeon: _____ Assistant: _____

Patient Name: _____

Patient DOB: ____/____/____ Patient SS # _____ Gender: Male Female

Patient Address: _____
Street Address City Zip Code

Patient Contact Number(s): H _____ W/Cell _____

Please provide ICD9 code and *EXACT* wording, without abbreviations, for the procedure

Diagnosis: _____ ICD9 Code: _____

Procedure (Please provide specifics, i.e. R, L, or Bilateral): _____

_____ CPT Code: _____

Special Equipment / Implant Request: _____

Estimated Length of Surgery: _____

Primary Insurance: _____ Pre-Certification Phone#: _____

Policy / ID #: _____ Group #: _____ Pre-Certification Date: _____

Authorization / Reference #: _____ Duration of Pre-Certification: _____

Policy Holder Name & SS #: _____

Secondary Insurance: _____ Pre-Certification Phone #: _____

Policy ID #: _____ Group #: _____

WC Carrier Name: _____ WC Claim #: _____

Adjuster Name & Phone #: _____

Area / of the Injury: _____ Date of Injury: _____

Comments: _____

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