HONORHEALTH

☐ New Case ☐ Existing Case

Surgery Scheduling Request Form

Phone: 480-534-4600 Fax: 480-882-7874 Email: HonorHealthPeriopScheduling@honorhealth.com

This is not a Preoperative order This is only a case booking request. All information in **BOLD** type is required to avoid scheduling delays.
If you are making changes to the Location, Patient Class or CPT code please contact the patient's insurance company and update the authorization.

Today's Date:_____ **Scheduler Name:**_____ **Contact Number:** _____

PATIENT INFORMATION:

Last Name:_____ **First Name:**_____ **MI:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Date of Birth:_____ SSN (if available):_____ **Sex:** ☐ Male ☐ Female

Home Phone #:_____ Cell Phone#_____ **Email address:**_____

CASE INFORMATION: Location (choose one)

☐ DV IP MAIN	☐ DV CATH	☐ DV ENDO	☐ JCL IP MAIN	☐ JCL OP	☐ JCL CATH
☐ JCL ENDO	☐ SONORAN IP OR	☐ SONORAN CATH	☐ OSBORN IP OR	☐ OSBORN CATH	☐ OSBORN ENDO
☐ GREENBAUM	☐ SHEA IP OR	☐ SHEA CATH	☐ SHEA ENDO	☐ PIPER	☐ TPK IP OR
☐ TPK CATH	☐ TPK ENDO	☐ FOUR PEAKS OR	☐ FOUR PEAKS CATH	☐ FOUR PEAKS ENDO	☐ TEMPE IP OR
☐ TEMPE CATH	☐ TEMPE ENDO				

Primary Surgeon:_____ Assist:_____ Second Surgeon: _____

Date of Service:_____ **Start Time:**_____ **Procedure Length**_____

Admission Type: ☐ Outpatient ☐ Pre-Inpatient ☐ Short Stay Admit (23 Hour Observation) ☐Inpatient (Currently Admitted)

JCL 3rd Floor Request ☐ Yes ☐ No **Length of Stay** (days)_____ Preoperative Medical Evaluation (OSBORN & JCL ONLY) ☐ Yes ☐ No

Diagnosis: _____

ICD 10 code(s):_____ **CPT code(s):** _____

Procedure (Permit to Read): _____

Anesthesia Type: ☐ General ☐ Local ☐ MAC ☐ Spinal ☐ Conscious ☐ Block ☐ None ☐ Other _____

Anesthesia Provider: ☐ Valley Anesthesia ☐ Camelback Anesthesia ☐ N/A ☐ Other: _____

Special Needs Inst/Equip/Implants/Vendor:

_____

_____

INSURANCE INFORMATION:

Primary Insurance Carrier Name:_____ **Phone# (if available):** _____

Group**#/ID #/Claim #:**_____ **Date of Injury (if available):** _____

Authorization Status: ☐ N/A ☐ Pending ☐ Authorized (Number): _____

Secondary Insurance Carrier Name:_____ **Phone # (if available):** _____

Group**#/ID #/Claim #:**_____ **Date of Injury (if available):** _____

Authorization Status: ☐N/A ☐ Pending ☐ Authorized (Number):: _____