

THS Surgery Scheduling Booking Sheet

Facility: _____

Patient Name: Last _____ First _____ Middle _____ Suffix _____

DOB: ____ / ____ / ____ Social Security Number: _____ - _____ - _____ Sex at Birth: _____

Address: _____

Home Phone #: _____ - _____ - _____ Cell Phone #: _____ - _____ - _____

Admission Status after Surgery _____

Type of Case (circle one): Elective Priority Elective (authorization is a priority)

Surgeon: _____ Assisting Surgeon: _____

Date of Surgery: ____ / ____ / ____ Time Surgery Requested: _____ PAT Preference Date: _____

Diagnosis: _____

Procedure(s) – include Site/Side: _____

CPT Codes(s) used to Obtain Authorization: _____

ICD-10 Code(s) used to Obtain Authorization: _____

Anesthesia Type Requested (circle one): _____ OTHER: _____

LATEX ALLERGY (needs to be 1st case of day): _____ Other Allergies: _____

Imaging Needed During Case: YES NO Type: _____ Pathologist Needed During Case: YES NO

Visual Acuity/Function for Cataract Procedures: YES NO Medicaid Sterilization Form: YES NO

Special Tools/Equipment for Case: _____

Required H&P Attached for Dental, Pediatric and Podiatry Cases YES NA

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Physician Authorization: _____ or NPR _____ Valid Dates for Procedure: _____

Facility Authorization: _____ Valid Dates for Procedure: _____
(required if < 72 business hours before case)

Facility NPI: SFH - 1891732889 TMH - 1316925506

Fax to Appropriate Surgical Area: TMH Ambulatory: 304-414-2720 STF Endo/Minor: 304-414-4941
TMH Endo/Minor: 304-414-2719 STF ODSC: 304-347-6297
TMH Main OR: 304-766-4451 STF Main OR: 304-347-6894

<p>THS Surgery Scheduling Booking Sheet THS-5007 (11/17; Version 2.0) CC Page 1 of 1</p>  <p>* 0 P 0 2 8 0 *</p> 	<p>Chart Copy</p> <p>USE LABEL OR PRINT PATIENT ID HERE</p>
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