GASTROENTEROLOGY PROCEDURE REQUEST AND PRECERTIFICATION FORM

Date:____________ D.O.B.: ______________________________

Patient Name: ____ SSN: ______________________________

Gastroenterologist: __________________________________

Patient Address: ______________________________ City: __________________ State: _____ Zip: _______

Patient Telephone (H): ________________________ (W): ____________________________________

Procedure: _____________________________________ Are you diabetic? __________________________

Procedure Code(s): ____

Diagnosis: ____

Diagnosis Code(s): ____________________ / _______________________ / ________________________

Hospital Preference: ☐ Fairfax Hospital ☐ Fair Oaks Hospital ☐ Office

Dates Not Available:____

Insurance Plan: ____

Insurance ID Number: __________________________ Group: _________________________________

Insurance Telephone Number: ____

Type of Anethesia __________________________ Special Equipment _________________________

Preparation Given: Office: _________________________ Mailed: ____________________________

Last Office Visit: __________________________________

Scheduled date & time of procedure: ____

Hospital: ____________________________ Posted by: ______________________________________

Patient notified: ______________________________ Initials: __________________________________

tda10/03