Advanced Surgery Center of Metairie

Fax: (504) 324-5995 • Phone: (504) 250-2175

SCHEDULING SHEET

☐ Previous Patient	Surgery Center Scheduler _____		
Today's Date:	Surgeon:	Office Scheduler:	
Patient:	SS#:	DOB:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Email Address:			
Procedure Date:	**Procedure Time:**	**Duration:**	
Workman's Comp Case: ☐ YES ☐ NO	**Date of injury:**		
CPT:	**Description:** ☐ **Left** ☐ **Right** ☐ **Bilateral**		

ICD 9 Codes				
Anesthesia Type:	**LOCAL**	**MAC**	**GENERAL**	**C ARM? q Y q N**
Equipment Needed:				
Implant Needed:				

PRIMARY

Insurance:_____ ID#: _____
Group: _____ Effective Date: _____
Contact Name: _____ Phone#: _____
Patient's Name: _____
Patient's DOB: _____ SS#: _____
Insured's Name: _____
Insured's DOB: _____ Insured's SS#: _____
Pre-Existing? ☐Y ☐ N Implants Covered? ☐Y ☐ N ___%
Pre-Cert for Facility? ☐Y ☐ N Pre-Cert # _____

IN-NETWORK	OUT-OF-NETWORK
% Covered _____	% Covered _____
Deductible _____	Deductible _____
Amount Met _____	Amount Met _____
Co-Pay_____	Co-Pay_____
OOP_____	OOP_____
Confirmed by: _____	Confirmed by: _____

Insurance Card Attached? _____

SECONDARY

Insurance:_____ ID#: _____
Group: _____ Effective Date: _____
Contact Name: _____ Phone#: _____
Patient's Name: _____
Patient's DOB: _____ SS#: _____
Insured's Name: _____
Insured's DOB: _____ Insured's SS#: _____
Pre-Existing? ☐Y ☐ N Implants Covered? ☐Y ☐ N _____%
Pre-Cert for Facility? ☐Y ☐ N Pre-Cert # _____

IN-NETWORK	OUT-OF-NETWORK
% Covered _____	% Covered _____
Deductible _____	Deductible _____
Amount Met _____	Amount Met _____
Co-Pay_____	Co-Pay_____
OOP_____	OOP_____
Confirmed by: _____	Confirmed by: _____

Insurance Card Attached? _____

FOR ASC USE ONLY:

Co-Pay Amount Due: _____ Patient Notified By: _____ Payment Plan? _____

Date Entered in System: _____ Entered By: _____