Covenant HEALTH

Pre-Registration Notes

Print Date/Time: 11/29/201611:04 am

F-prm3.rpt

Account_____ Date of Review_____

Date of Service: 11/30/2016 Patient Type: DS Service Type: _____ MRN: [redacted]

Patient Name: [redacted] SSN: [redacted] DOB: 10/3/79

Referring Physician: SAUNDERS, ERIN PCP: UNKNOWN, UNKNOWN

Dx: PRETESTING

Room: SCHED-4-F

Date/Time: 11/30/16 9:45 .12/22 LAPAROSCOPIC TOTAL HYSTERECTOMY W BILATERAL SALPINGECTOMY W SLING ROBOTIC ASSISTED

Precert: HUMANA-cov hlth (105250400-ID #)

Primary Insurance

Covered Benefit? Y N
Referral Required? Y N

Insured Name_____ Relationship_____

ID #_____ Group #_____

Employer_____

Insurance/WC_____ Plan #_____

Claims Address_____

_____

Ver.Phone #_____ Rep. Spoken to_____

Effective Date_____ Ded_____ Ded Met_____ Copay_____

%_____ OOP_____ Life Max_____

Medicare_____

PRECERT YES NO PreCert Phone _____

Precert Given by_____PreCert #_____DS 23hr IP OP NV

Secondary Insurance

Insured Name_____ Relationship_____

ID #_____ Group #_____

Employer_____

Insurance/WC_____ Plan #_____

Claims Address_____

_____

Ver.Phone #_____ Rep. Spoken to_____

Effective Date_____ Ded_____ Ded Met_____ Copay_____

%_____ OOP_____ Life Max_____

Medicare_____

PRECERT YES NO PreCert Phone _____

Precert Given by_____PreCert #_____DS 23hr IP OP NV