Manalapan Surgery Center

50 Franklin Lane, Suite 101, Manalapan, NJ 07726 Tel: (732) 617-5990 Fax: (732) 862-1154

PATIENT BOOKING FORM

Medicare Private/Commercial NJ-PIP NY-NoFault WC LOP Self-Pay

Today's Date:	Diabetic? ☐ YES ☐ NO	Previous Admission: ☐ YES ☐ NO
Patient's First Name:	Last Name:	Social Security #:
Gender:		Date of Birth
Height:	Weight	BMI:
Patient's Home Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work#
Notify in Case of Emergency:	Phone#	Relationship:

Primary Insurance:	Claims Address:	
Insurance Co. Phone#:	Adjuster Contact Info:	
Policy ID#:	Claim#:	DOA/DOL

Secondary Insurance:	Claims Address:	
Insurance Co. Phone#:	Adjuster Contact Info:	
Policy ID#	Claimit:	DOA/DOL:
Attorney's Name:	Attorney's Phone:	I Attorney's

PRIVATE INSURANCE/WC/PIP CASES MUST HAVE PRIOR AUTHORIZATION FOR APPROVED TREATMENT

Date of Procedure:	Time of Procedure:	
Procedure:		Diagnosis:
CPT Codes:		ICD 10 Code:
Anesthesia Type:	Referring Physician:	Phone#
Surgeon Requires Assistant YES NO	Assistant Name:	Assistant Phone#:
Specific Supplies and/or Equipment		
Patient Requires Rehabilitation? (i.e. CAREONE): YES/NO		
Patient Needs Transportation:		
Pick-up Address (If different from Above):		
Schedulers Contact info:		
Name:	Phonett	Fax#

MUST FAX BACK WITH LEGIBLE COPY OF PATIENT'S INSURANCE CARD: FRONT

Revised 8/1/16

MANALAPAN SURGERY CENTER
ELIGIBILITY & BENEFITS VERIFICATION FORM

Patient Name (Last, First): _____ **, Date of Birth:** _____

Insured Name (Last, First): _____ **, Date of Birth:** _____

Insurance Company Name: _____ **Phone** _____

COMMERCIAL INSURANCE

.....FACILITY IS NOT PAR WITH ANY COMMERCIAL CARRIER. IF NO OUT OF NETWORK BENEFITS PROCEDURE CANNOT BE DONE

Policy # **Group #** _____ **Effective Date:** _____

Coverage: Yes / No Covered @ %, Procedure Being Authorized _____ **Precert Needed: Yes I No**

Authorization #: _____ **CertifierName:** _____ **Phone:** _____ **Fax:** _____

Deductible: $ Amount met $ _____ **Out of Pocket: $** ____**, Amount met: $** _____ **Co- Insurance** ___**%**

NO-FAULT/PIP

Policy # _____ **Claim*** _____ **DOA:** _____

State Policy Written: NY / NJ / OTHER_____

NEW YORK

Case Open: Yes No, Benefits Exhausted: Yes / No, Amount Left on Policy: $_____ **, Pending IMEIEUO: Yes 1 No**

Type of IME: _____ **Date IMEIEUO Scheduled:** _____

Adjuster Name _____ **Ph•**_____ **, Ext:** _____

NEW JERSEY

Health Insurance Primary? Yes I No Copy of Policy Declaration Page on File: Yes No Authorization on file : Yes I No

Authorization Expiry Date:

If not authorized, is proof of pre-cert with fax confirmation on file : Yes *I* No, Proof of Appeal: Yes I No

Certifier Name: _____ **Phone:** _____**, Fax:**_____

Adjuster Name _____ **Ph:** _____ **, Ext:**_____ **Fax:** _____

Patients Attorney Name: _____ **, Ph:** _____ **Fax:** _____

WORKERS COMPENSATION

WCB _____ **CC#** _____ **DOA:**_____

Case Still Open: Yes No Established Body Parts:_____

Adjuster Name_____**Ph:** _____ **Ext:** _____

Claim Submission Address:

_____

_____

Representative Name: _____ , Ref it _____ , Information taken by: _____ , Date: _____

Additional Notes: _____

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #		**WCB Group**	

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			