Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

OR BOOKING FORM

Please Fax Completed Form to: (732) 680-8883/ (732)499-7568

Procedure Date: _____ Time _____ AM/PM/TF (To Follow)

Primary Surgeon: _____ Primary Physician: _____

Pt's Last Name: _____ First Name: _____ Middle Initial: _____

DOB: SS#: Gender:_____

Home #: _____ Cell #:

Address: _____City:_____ State: _____Zip:_____

Pharmacy: _____ Location: _____ Phone: _____

Admitting DX & ICD Codes:

Procedures & CPT Codes:

_____

(**Please include FULL description of Procedures and CPT/ICD Codes**)

Instrumentation/Implant/Graft/Tissue Needed: ___ Yes/___ No **C-Arm** _____
1st Company: _____ Rep.: _____ Phone #: _____
2nd Company: _____ Rep.: _____ Phone #: _____

Physical Therapy (Crutch /Walker Training): ___ Yes No (if YES please send orders attached)

PRIMARY INSURANCE: PLEASE FILL OUT OR FORWARD COPIES OF BOTH SIDES OF INSURANCE CARDS
Insurance Co: _____ Phone #: _____
Policy#/Claim#:_____ Group#:_____
Subscriber:_____ _____Relationship to Patient:
Subscriber DOB: _____ Age:____Subscriber Contact #:

SECONDARY INSURANCE:
Insurance Co: Phone #: _____
Policy#/Claim#:_____ Group#:_____
Subscriber: Relationship to Patient:
Subscriber DOB: Age:____Subscriber Contact #: _____

Pre-Cert #:_____ Pre-Cert Date: _____ No Pre-Cert Req: ____

Patient Status Order: **(Please check only one)**

SDS (anticipate discharge on same calendar day)
SDS with Extended Recovery (anticipate overnight stay) _____
Minor Surgery
Admit to Inpatient _____

P.A.T. Date: Time: _____ AM/PM Booked w/

Surgeon Signature: Date: Time: _____ AM/PM

PLEASE CALL (732)499-6145/6017 TO CANCEL or RE-SCHEDULE PROCEDURES
Revised 10/11/17 pdy

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			