

# 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:			
Insurance Co. Phone#:		Claims Address:	
Policy ID#:		Adjuster Contact Info:	
		Claim#:	DOA/DOL
Secondary Insurance:			
Insurance Co. Phone#:		Claims Address:	
Policy ID#		Adjuster Contact Info:	
		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:	Gurbir Johal, MD	
Procedure:		Diagnosis:	
CPT Codes:		LCD 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:		YES/ NO	
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**

**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 / No

Authorization #: \_\_\_\_\_ Certifier Name: \_\_\_\_\_ 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 IME/IEUO: Yes / No

Type of IME: \_\_\_\_\_ Date IME/IEUO Scheduled: \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Ph• \_\_\_\_\_, Ext: \_\_\_\_\_

**NEW JERSEY**

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

Authorization Expiry Date: \_\_\_\_\_

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