Insurance Communication



Insurance Company: BCBS AETNA HUMANA CIGNA W/C UHC SELFPAY Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TBD Note: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Post-op Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Post-op Time\_\_\_\_\_:\_\_\_\_\_ AM/PM

Patient Name; Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_

**TO RESCHEDULE/CANCEL YOUR PROCEDURE CONTACT PSGC AT 630-371-9980 & SURGICAL CENTER 24 HOURS**

**BEFORE SCHEDULED PROCEDURE DAY OR A $100 NO SHOW FEE WILL BE CHARGED TO YOUR ACCOUNT**

**Dr. Scott Glaser Dr. Ira Goodman Dr. Scott McDaniel**

**\*\*\* The surgical center will call you with a time of arrival and instructions\*\*\*Procedure order is only valid for 30 Days\*\*\***

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| --- | --- | --- | --- |
| **MAGNA SURGERY CTR.**  7456 S. State Road  3rd Floor  Bedford Park, IL 60638  (773) 445-9696  Weight Limit: 400lbs | **PALOS SURGICENTER**  7340 W College Dr  Palos Heights, IL, 60463  (708) 361-3233  Weight Limit: 500lbs | **HINSDALE SURGICAL CTR.**  10 Salt Creek Lane  Hinsdale, IL 60521  (630) 325-5035  Weight Limit: 400lbs | **ILLINOIS SPORTS MEDICINE AND ORTHOPEDIC SURGERY CENTER**  9000 Waukegan Rd, Ste 120  Morton Grove, IL 60053  (847) 213-5444  Weight Limit:400 |

|  |  |
| --- | --- |
| **Oak Brook Surgical Center**  2425 W. 22nd Street  Suite 101 Oak Brook, IL 60523  (630) 990-2212  Weight Limit: 700 | **Ashton Surgical Center**  Suite 100  1800 McDonough  Hoffman Estates, IL 60192  (847) 742-7272  Weight Limit: 400-500 |

**\*\*\*ABOVE FACILITY’S AND ANESTHESIOLOGIST FEES ARE SEPARATE ENTITY’S FROM PSGC\*\*\***

**Procedure: CPT CODES:**

bd21504_ Transforaminal Epidural Steroid Inj Lumbar: 64483-64484 Cerv or Thor: 64479-64480

bd21504_ Facet Joint Injection Lumbar: 64493-64494-64495 Cerv or Thor: 64490-64491-64492

bd21504_ Medial Branch Nerve Block Lumbar: 64493-64494-64495 Cerv or Thor: 64490-64491-64492

bd21504_ Radiofrequency Ablation Lumbar: 64635-64636 Cerv or Thor: 64633-64634

# bd21504_ Shoulder / Knee Injection 20610

#### bd21504_ Hip Injection 27093

# bd21504_ Sacroiliac Joint Injection 27096

# bd21504_ Translaminar Epidural Steroid Inj Lumbar: 62323 Cerv or Thor: 62321

# bd21504_ Interlaminar Epidural Steroid Inj Lumbar: 62323 Cerv or Thor: 62321

bd21504_ Caudal Epidural Steroid Injection 62323

bd21504_ Intercostal Nerve Single: 64420 Multiple: 64421

bd21504_ Stellate Ganglion Block 64510

bd21504_ Lumbar Paravertebral Sympathetic Nerve Block 64520

Destruction by Neurolytic agent, 64620

bd21504_ Ultrasound (In Office Injection) 76942

Side(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional/Other Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPT Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a patient I fully understand failure to call my insurance company may result in non-payment and I can be held responsible for the outstanding balance. Benefits verification contains general reimbursement information based on medical necessity and is not a guarantee of payment by my insurance company and is provided to me by PSGC- I am fully responsible for any balance due to non-payment by my insurance company.

\*\*\*\*\*\*Insurance Companies that require authorization: IN/OUT Network Benefits Please See Attached\*\*\*\*\*\*

Ins. Rep. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_Call Ref. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pre-certification Required: Y/N

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ PSGC Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_