

ELECTIVE IMPLANT AUTHORIZATION FORM

Submission Date:

PATIENT INFORMATION

Patient's Name:	Date of Birth:
Surgeon:	Proposed Date of Case/Procedure:
Case/Procedure DRG:	Scheduling Unit:
Insurance/Payor:	Vendor name(s):
Contracted Vendor: <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Preference: <input type="checkbox"/> Yes <input type="checkbox"/> No

ESTIMATED COST OF IMPLANT COMPONENTS


MFG Number	Item Description	Qty	Unit Cost	Ext Cost	Revenue Code*

*Attach Vendor Quote
Use Revenue Code Cheat Sheet to enter Revenue Code

Estimated Cost of Implant Components:	
Estimated Charges for Implant Components:	
Anticipated Reimbursement:	

CFO / Administration Approval Signature:	Approval Date:
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 	Account Number:	MR Number:
	Patient Name:	
	Admit Date:	

 503 Mcmillan Rd. - West Monroe, LA 71291	DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC
	Allergies:								
	Attending Physician Name:								