Island Ambulatory Surgery Center, LLC
2279 Coney Island Avenue, 1st Floor Brooklyn, NY 11223
Phone: 718.998.9400 Fax: 718.998.9401

Date of Surgery: _____

Patient Name: _____ DOB: _____

Anesthesia Type: □ Local □ MAC □ General □ Other_____

Procedure Name	**Procedure Code (CPT)**	**Diagnosis (ICD-9)**
Cervical ESI	62310/77003	722.0 723.4
Cervical Facet	64490/64491/64492	721.0 723.8
Cervical RF	64633/64634/77003	721.0 723.8
Cervical Discogram	62291/72285	727.0 723.4
Cervical Discectomy	62287	722.0 723.4
Thoracic ESI	62310/77003	722.11 724.1
Thoracic Facet	64490/64491/64492	721.1 724.1
Lumbar ESI	62311/77003	722.10 724.4
Lumbar TFESI	64483/64484	722.10 724.4
Lumbar Facet/MBN	64493/64494/64495	721.3 724.8
Lumbar RFA	64635/64636/77003	721.3 724.8
Lumbar Discogram	62290/72295	722.10 724.4
Lumbar Discectomy	62287/22526/22527	722.10 724.4
Lumbar Sympathetic Block	64520/77003	337.22 729.2
SI Joint Inj	27096	720.2 846.1
SI Joint RFA	64640/77003	720.2 846.1
Other		

Insurance info:

No Fault : Claim # _____ NF Policy # _____ DOA/DOI _____

Claim submission address: _____

Ins. Co _____ Adjuster name/number _____

Attorney name/address _____

Please include Initial consultation notes indicating medical necessity, narrative report (if available) MRI /X-Ray report and Dr's completed NF5 form

W/C: Claim # _____ WCB Policy # _____ DOA/DOI _____

Claim submission address: _____

Ins. Co _____ Adjuster name/number _____

Please include reason for surgery, narrative report (if available), MRI and/or X-Ray report Granted MG2 or C4 authorization for planned procedure (if available)

For Private Insurance, please include front/back copy of card, name of insured, etc…

*** For all Pts, Comprehensive History and Physical (H&P) within 30 days of DOS required***