Parkway Surgery Center
A Joint Venture with St. Rose Dominican and United Surgical Partners

Scheduling Form

Please fax to Mary:
Fax: (702) 616-4962
Efax: (702) 974-1106
Phone: (702) 616-4944

PHYSICIAN _____ Patient Acct # _____

CPT _____

_____ **DOS** _____

_____ **TIME** _____

PT. NAME _____ **SEX:** _____ **DOB:** _____

HOME PH#: _____ **INSURANCE** _____

INSURED'S EMPLOYER: _____ **DOI:** _____

SELECT ONE: ◯ **HMO** ◯ **POS** ◯ **PPO** ◯ **EPO**

PATIENT SS# _____ **INSURANCE ID#** _____
(incl. prefix/suffix)

INSURANCE PHONE # _____ **INSURED'S NAME** _____

SS# OF INSURED (if other than patient): _____ **AUTH #** _____

2ND INSURANCE: _____
(if applicable)
INSURED: _____ **INSURANCE ID#** _____
(incl. prefix/suffix)

INSURANCE PHONE # _____ **AUTH #** _____

PROCEDURE _____

_____

IMPLANTS _____

ICD-9 / DIAGNOSIS: _____

Special Request: _____

(PLEASE SELECT REQUESTS BELOW)

XRAY ☐ **Yes** | **No** ☐ **PREFERENCE: Mini C-Arm** ☐ **Large C-Arm** ☐

XRAY TECH NEEDED? ☐ **Yes** | **No** ☐

Anesthesia Group/Type: _____ **Length of Time:** _____

PSC Rep _____ **SCHEDULER'S NAME** _____

Date: _____ ***DATE:*** _____

***Items in **Bold Print** are required information!!*

We must also have a copy of each valid insurance card faxed to us.