|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| {Date} | | | | | | | | | | | | Elective Surgery Notification | | | | | | | | | | | | | |
| {Insurer's name}  {Address}  {City, state, ZIP}  {Phone number}  {Fax number} | | | | | | | | | | | |
| Re: | Worker name: | | | | | | |  | | | | | | | |  | Claim number: | | | | |  | | | |
|  | Date of birth: | | | | | | |  | | | | | | | |  | Date of injury: | | | | |  | | | |
|  | | | | | | | |  | | | | | | | |  |  | | | | | | | | |
| **Provider’s notice of proposed elective surgery** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Practice name: | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Ordering physician: | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Phone number: | | | | |  | | | | | | | | Fax number: | | | | | | |  | | | | | |
| **We have scheduled the following elective surgery for the above-named worker:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Procedure: | | |  | | | | | | | | | | | | | | | | | | | | | | |
| CPT codes: | | |  | | | | | | | | | | | Diagnosis/ICD-10: | | | | | | |  | | | | |
| Outpatient:  Inpatient: | | | | | | | | | Anticipated length of stay: | | | | | |  | | | | | | | | Date scheduled: | |  |
| Hospital/facility: | | | | | |  | | | | | | | | | | | | | | | | | | | |
| ***Provider: Attach supporting documentation (e.g., chart notes).*** | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | |  |  | | | | | | | |  | | | | | **5425** | |
| 440-5425 (6/25/DCBS/WCD/WEB) | | | | | | | | | | | | | | | | | |  |