|  |  |
| --- | --- |
| {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) |  |