Date

Insurer's name
Address
City, state, ZIP
Phone number
Fax number

Elective Surgery Notification

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).