{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 pending 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.***

DRAFT