Surgery/Procedure Information Request

Women's Health Connection (WHC) in Partnership with Access to Healthcare Network

Please do not schedule the surgery/procedure until you have received the processed referral back from WHC

PATIENT INFORMATION

Name:		DOB (DD/MM/YY):	
Today's Date (DD/MM/YY):		Insurance status:	☐ Medicaid ☐ Amerigroup ☐ HPN ☐ Uninsured

SURGERY INFORMATION

Surgeon:			
Name of facility/surgery center:		Expected date of surgery (DD/MM/YY):	
Name of surgery/procedure:			
CPT code(s):		☐ Global period ☐ days	☐ No global
Reason for surgery/procedure:			
WHC Anesthesia Group: CPT code:		Length of surgery:	
Preoperative testing CPT codes:			
WHC Pathology Provider:			

PROVIDER OFFICE INFORMATION

Requesting clinician:		Phone [ex. (111) 111-1111]:	
Clinician signature:			

PLEASE FAX COMPLETED FORM TO 775-284-1918 FOR WHC APPROVAL

Fax to the attention of: ☐ Marina ☐ Melissa ☐ Elena ☐ Victoria ☐ Mayra ☐ Angelica		☐ Approved	☐ Denied
Care coordinator:		Date (MM/DD/YY):	
RN		Date (MM/DD/YY):	

I, the undersigned, do attest that the above information is accurate and the above surgery/procedure conforms to the standard of care and is in compliance with the policies and procedures of the Women's Health Connection program.

State ID #:

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