FAX COMPLETED FORM TO:	**229-249-5061**
Pre Service Dept/STAT Call:	**229-259-4556**
Pre Service Manager Cell:	**229-539-3611**

ASSISTANCE REQUEST FORM FOR CLINICAL CERTIFICATION

ALL QUESTIONS MUST BE ANSWERED.
FAILURE TO DO SO MAY DELAY PROCESSING OF THIS REQUEST.
(Form Revised 01/05/2015)

☐ ***STAT***

(Check one please) *Location for Service to be performed:*

☐ SGMC Main Campus	☐ SGMC Smith Northview	☐ SGMC Berrien Campus	☐ SGMC Lanier Campus

PATIENT INFORMATION

Patient Name: ________________________ **Patient Social Security Number:** ________________

Patient DOB: ________________________ **Patient Phone Number:** ________________________

Patient's Address: ____

PROCEDURE INFORMATION

Date of Request: ________________ Contact Person: ____________________________

Date & Time of Appointment (if already scheduled): ____________________________

CPT Code(s): 1. __________ 2. __________ 3. __________ 4. __________

ICD-9 Code(s): 1. __________ 2. __________ 3. __________ 4. __________

Specific Extremities: ________________________ Orientation: ________________

☐ Inpatient or ☐ Outpatient & Length of Stay: ______________ Date of last office visit: ______________

For Surgery Scheduling Requests, Please Complete the Following:

Name of Surgeon: ____

Name of In-Office Scheduler: ____

Patient Status (*i.e.*, IP, TBA, OP, Outpatient Observation): ____________________________

Please attach all clinical documentation

REFERRING PHYSICIAN INFORMATION

Referring Physician: ________________________ **Specialty:** ________________________

Physician's Address: ________________________ **City:** ______________ **State:** __________

Physician's NPI #: ________________________ **Physician's Tax ID #:** ________________________

Physician's Fax #: ________________________ **Phone #:** ________________________

SIGNATURE: I authorize SGMC to obtain authorization.

Physician's Signature: ________________________ Date: ______________