

Hudson Surgery Center
234 East 23rd street, NY NY 10010
Phone: 2129517020 Fax: 8008674134

Date of Surgery: _____

Patient Name: _____ **DOB:** _____

Anesthesia Type: ☐ Local ☐ MAC ☐ General ☐ Other _____

Procedure Name	Procedure Code (CPT)	Diagnosis (ICD-9)	
Cervical ESI	62310/77003	722.0	723.4
Cervical Facet	64490/64491/64492	721.0	723.8
Cervical RF	64633/64634/77003	721.0	723.8
Cervical Discogram	62291/72285	727.0	723.4
Cervical Discectomy	62287	722.0	723.4
Thoracic ESI	62310/77003	722.11	724.1
Thoracic Facet	64490/64491/64492	721.1	724.1
Lumbar ESI	62311/77003	722.10	724.4
Lumbar TFESI	64483/64484	722.10	724.4
Lumbar Facet/MBN	64493/64494/64495	721.3	724.8
Lumbar RFA	64635/64636/77003	721.3	724.8
Lumbar Discogram	62290/72295	722.10	724.4
Lumbar Discectomy	62287/22526/22527	722.10	724.4
Lumbar Sympathetic Block	64520/77003	337.22	729.2
SI Joint Inj	27096	720.2	846.1
SI Joint RFA	64640/77003	720.2	846.1
Other			

Insurance info:

No Fault : Claim # _____ NF Policy # _____ DOA/DOI _____

Claim submission address: _____

Ins. Co _____ Adjuster name/number _____

Attorney name/address _____

**Please include Initial consultation notes indicating medical necessity, narrative report (if available)
MRI /X-Ray report and Dr's completed NF5 form**

W/C: Claim # _____ WCB Policy # _____ DOA/DOI _____

Claim submission address: _____

Ins. Co _____ Adjuster name/number _____

**Please include reason for surgery, narrative report (if available), MRI and/or X-Ray report
Granted MG2 or C4 authorization for planned procedure (if available)**

For Private Insurance, please include front/back copy of card, name of insured, etc...

*** For all Pts, Comprehensive History and Physical (H&P) within 30 days of DOS required***