

PATIENT INFORMATION

First Name: _____ Middle Name/Initial: _____ Last Name: _____
 Date Of Birth: _____ Gender: ☐ Male ☐ Female ☐ Unspecified
 Address: _____ Phone Number: _____
 E-Mail: _____

INSURANCE INFORMATION

Type of Coverage: ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Managed Medicaid
☐ Commercial ☐ Worker's Comp ☐ Tricare ☐ Other

Primary Insurance Name: _____
 Primary Policy Number: _____
 Primary Group Number: _____
 Policy Holder: _____
 Policy Subscriber Date of Birth: _____
 Relationship to Patient: _____
 Primary Insurance Phone Number: _____

Type of Coverage: ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Managed Medicaid
☐ Commercial ☐ Worker's Comp ☐ Tricare ☐ Other

Secondary Insurance Name: _____
 Secondary Policy Number: _____
 Secondary Group Number: _____
 Policy Holder: _____
 Policy Subscriber Date of Birth: _____
 Relationship to Patient: _____
 Secondary Insurance Phone Number: _____

DIAGNOSTIC AND CODING INFORMATION

Primary Diagnosis: _____ Secondary Diagnosis: _____
 Date of Surgery: _____ Laterality of planned procedure: ☐ Left ☐ Right ☐ Bilateral

CPT Codes:

☐ **0505T** Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion

☐ Other Code(s): _____

PROCEDURE PROTOCOL

Site of Service: ☐ Inpatient Hospital (21) ☐ Outpatient Hospital (19) Off-Campus ☐ Outpatient Hospital (22) On Campus

PHYSICIAN INFORMATION

Practice Name: _____
 Phone: _____ Address: _____
 NPI: _____ Tax ID: _____
 Physician Name: _____
 Primary Contact: _____
 Contact Phone: _____ Contact Email: _____

FACILITY INFORMATION

Facility Name: _____
 Phone: _____ Address: _____
 NPI: _____ Tax ID: _____
 Physician Name: _____
 Primary Contact: _____
 Contact Phone: _____ Contact Email: _____

REQUIRED DOCUMENTATION



Front & Back Insurance Card



Clinical Documentation