Request for Surgery Outside of the Foot & Ankle Surgery Center

Physician: _____ Office: _____

Patient Name: _____ SSN: _____

Patients Date of Birth: _____ Insured person: _____
_____

Name of Insurance:_____

Insurance ID: _____ Insurance Phone Number: _____

Procedure: _____

To be scheduled at what facility:_____

Surgery anticipated date and time:_____
Explanation: (Why surgery needs to be done outside the Foot & Ankle Surgery Center and explanation must include type of insurance).

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Physician Signature: _____ Date: _____

Approved: _____ Disapproved: _____

By: _____ Date: _____

Copy: Anthony E. Miller DPM
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