ELECTIVE IMPLANT AUTHORIZATION FORM

	Submission Date:

PATIENT INFORMATION

Patient's Name:	Date of Birth:
Surgeon:	Proposed Date of Case/Procedure:
Case/Procedure DRG:	Scheduling Unit:
Insurance/Payor:	Vendor name(s):
Contracted Vendor: ☐Yes ☐No	Physician Preference: ☐Yes ☐No

ESTIMATED COST OF IMPLANT COMPONENTS

MFG Number	Item Description	Qty	Unit Cost	Ext Cost	Revenue Code*

Attach Vendor Quote
**Use Revenue Code Cheat Sheet to enter Revenue Code*

Estimated Cost of Implant Components:	
Estimated Charges for Implant Components:	
Anticipated Reimbursement:	

CFO / Administration Approval Signature:	**Approval Date:**

Account Number:	MR Number:
Patient Name:	
Admit Date:	

DOB	Age	Sex	HT	WT	RM-BD	PT	SVC	FC

Allergies:
Attending Physician Name:

The Medical Center OF SOUTHEAST TEXAS
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