



Urology Booking Form

Gramercy Surgery Center, Inc
 (212) 254-3570 Fax: (866) 249-5146

Surgeon:		Asst. Surgeon:		Location: <input type="checkbox"/> Manhattan <input type="checkbox"/> Queens	
Date Requested:	Start Time:	OR Duration:	Anesthesia Type:		

Patient Information

Last Name:	First Name:
Street Address:	City/State/Zip:
DOB:	Home Phone:
Cellular Phone:	Work Phone:
SSN:	<input type="checkbox"/> Male <input type="checkbox"/> Female
PCP Name:	PCP Phone:
Email:	

Insurance Information

Primary Insurance	Policy Number	Subscriber	DOB
Insurance Phone	Authorization		
Secondary Insurance	Policy Number	Subscriber	DOB

Primary Procedure Name: Please check all procedures being performed

Bladder Botox Injection – 52287/J0585	Circumcision - 54161	Cysto, Biopsy, & Fulguration – 52354	
Cysto, Int. Optical Urethrotomy – 52276	Cysto, Laser Litho – 52315	Cysto, Ureteroscopy – 52351	
Cysto, Uret., Litho w/ Stent – 52356	Cystolithopaxy – 52317	Cystoscopy – 52000	
Cystoscopy & Stent Removal – 52310	Epididymis Local Lesion Excision – 54830	Frenulotomy – 54164	
Hydrocelectomy (Unilateral) – 55040	Lithotripsy (Left) – 50590	Lithotripsy (Right) – 50590	
Micro – TESE – 55899	Nesbit Plication – 54360	Orchiectomy – 54520	
Penile Implant (Inflatable) – 54405	Penile Implant (Remove/Replace) – 54410	Penile Implant (Semi Rigid) – 54400	
Prostate Biopsy – 55700	Seeds – 55875	Spermatocoe Excision – 54840	
Testicular Prosthesis Insertion – 54660	TURBN – 52500	TURBT – 52234	
TURBT – 52235	TURBT – 52240	Turp with Button/Loop – 52601	
Ureteral Stent Insertion – 52332	Urography/Retrograde Study – 74420	Vaporization of Prostate – 52648	
Varicocelectomy – 55530		Vasovasectomy – 55400	

Other Procedures: _____ CPT Codes: _____

Diagnosis (ICD-10): _____

Antibiotics to be administered before Pre-Op: No Yes : _____

Please check supplies needed:

Bipolar Loop	Button	Cold Knife	
Cytoscope (Flex or Rigid)	C-Arm	DVUI Set	
Holmium Laser	Hot Knife	JJ Stent	
Monopolar Loop	Stone Basket	Urethral Balloon	
Ureteroscope (Flex or Semi-Rigid)			

Other Supplies/Equipment: _____

Rep. Requested	Name of Rep:
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Please fax a copy of the front and back of the patient's insurance card.

Person completing form _____ Phone: _____ Date: _____