Urology Booking Form

Gramercy Surgery Center, Inc
(212) 254-3570 Fax: (866) 567-3772

Surgeon:	Asst. Surgeon:	Location: ☐ Manhattan ☐ 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:	☐ Male ☐ 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		Cystolithopaxxy – 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 (Inflattable) – 54405		Penile Implant (Remove/Replace) – 54410		Penile Implant (Semi Rigid) – 54400	
Prostate Biopsy – 55700		Seeds – 55875		Spermatocele 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		Vasectomy - 52240		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:

Please fax a copy of the front and back of the patient's insurance card.

Person completing form _____ **Phone:** _____ **Date:** _____