SURGERY/PROCEDURE INFORMATION REQUEST

Women's Health Connection (WHC) in Partnership with Access To Healthcare Network (AHN)

Please do not schedule the surgery/procedure until you have received the processed referral back from WHC

Patient Information			
Name:		Date of Birth:	
Today's Date (DD/MM/YY):		Insurance Status: Medicaid: ☐ Amerigroup: ☐ HPN: ☐ Uninsured: ☐	
Surgery Information			
Surgeon:			
Name of facility/surgery center:		Expected date of surgery (DD/MM/YY):	
Name of Surgery/Procedure:			
CPT Codes:	Global Period: ☐ Days:	No global: ☐	
Reason for surgery/procedure:			
WHC/Anesthesia Group CPT code:		Length of surgery:	
Preoperative testing CPT codes:			
WHC Pathology Provider:			
Provider Office Information			
Requesting clinician:		Phone #:	
Clinician signature:			
Please Fax Completed From to 775-284-1918 for WHC Approval			
Fax to ATTN: Angie: ☐ Melissa: ☐ Elena: ☐ Mayra: ☐ Ingrid: ☐ Victoria: ☐ Approved: ☐ Denied: ☐			
Care Coordinator:		Date (MM/DD/YY):	
RN:		Date (MM/DD/YY):	
I, the undersigned, do attest that the above information is accurate and the above surgery/procedure conforms to the standard of care and is in compliance with the policies and procedures of the Women's Health Connection Program.			
State ID #:			

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