

TO BE COMPLETED BY ATTENDING PHYSICIAN
NAME OF PATIENT:
NAME OF PRIMARY INSURED:
NAME OF ATTENDING PHYSICIAN:
PROPOSED DATE OF SURGERY:
DESCRIPTION OF SURGICAL PROCEDURES:
STATE DIAGNOSIS:
NAME OF HOSPITAL:
ESTIMATED LENGTH OF CONFINEMENT:
COST OF:

ESTIMATED FEE

COMPANY LIABILITY

SURGICAL PROCEDURES:
ANESTHETIC FEE:
ROOM & BOARD:
IN-HOSPITAL MISCELLANEOUS EXPENSES:
STATE DIAGNOSTIC TESTS COMPLETED PRIOR TO THIS RECOMMENDED SURGERY
DOCTOR'S SIGNATURE _____

DATE _____

FOR OFFICIAL APPROVAL
AUTHORIZED SIGNATURE _____

DATE _____