

Claimant: _____
 Medicare #: _____
 Diagnosis: _____
 Physician: _____

Claim #: _____
 Date of Accident: _____
 Part of the body: _____
 Payee #: _____

Primary surgery <input type="radio"/>	Surgical assistant GP <input type="radio"/>	Surgical (assistant) specialist <input type="radio"/>
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Surgery date: _____ Surgery start time: _____ Surgery authorization #: _____

Collaborative surgery

Note: WorkSafeNB uses the *Medicare Manual* to guide its payment for surgical procedures.

1. Please list each procedure on a separate line.
2. Indicate in second column if the procedure is related to primary surgery (P) secondary surgery same incision (2S) or secondary surgery different incision (2D).
3. Adjusted units = Medicare units adjusted for collaborative surgery or surgical assistance (Do NOT add after-hour adjustments in this column).
 Unadjusted medicare units = units list in *Medicare Manual*.
4. Filing bonus is calculated automatically by our system. Please use the base unit rate for > 5 days in the unit rate column.
5. Elective surgery must be pre-authorized. Collaborative surgery must be pre-authorized.

Procedure #	Procedure	Medicare Code	(unadjusted) Medicare Manual Units	Adjusted Units	Unit Rate	Fee
1	Primary Surgery					
2	<input type="checkbox"/> P <input type="checkbox"/> 2S <input type="checkbox"/> 2D					
3	<input type="checkbox"/> P <input type="checkbox"/> 2S <input type="checkbox"/> 2D					
4	<input type="checkbox"/> P <input type="checkbox"/> 2S <input type="checkbox"/> 2D					
5	<input type="checkbox"/> P <input type="checkbox"/> 2S <input type="checkbox"/> 2D					
6	<input type="checkbox"/> P <input type="checkbox"/> 2S <input type="checkbox"/> 2D					
7	Section 21 List Procedure					
8	Section 21 List Procedure					
9	BMI > 40 <input type="checkbox"/> yes					
					Total	

Comments: _____

Adjusted for after-hours: _____
 Adjusted for expedited: _____
 Adjusted total: _____

Physician Office Stamp

or
 Physician Address: _____
 City, Town, Village: _____
 Postal Code: _____
 Phone: _____

I declare that this is a correct statement of services rendered by me for which I have received no payment.

Signature: _____

Date: _____

This form should be faxed to WorkSafeNB at 1 888 629-4722.