

Patient Information	Patient Name: _____ M/F (please circle) Date of Birth: _____ Social Security Number: _____ Address: _____ _____ City, State, Zip: _____ _____ Phone: _____ Height: _____ Weight: _____ BMI: _____
Surgeon Information	Surgeon Name: <u>Darin M. Minkin</u> Tax ID#: <u>56259 2570</u> Specialty: <u>Surgery-General, lap, and bariatric</u> Site Name: <u>Darin M. Minkin, D.O.</u> Office Contact Name: <u>Jill</u> Address: <u>2355 Dougherty Ferry Road Suite 430</u> City, State, Zip: <u>St. Louis, MO 63122</u> Phone: <u>314-965-8410</u> Fax: <u>314-965-8756</u> NPI #: <u>1043296494</u>
Procedure Information	Primary ICD-9 Code: <u>278.01</u> Secondary ICD-9 Code <u>278.01</u> CPT Code 1: <u>43770</u> CPT Code 2: <u>S2083</u> CPT Code: <u>43775</u> Site of Service: <input type="radio"/> Ambulatory Surgical Center (ASC) <input checked="" type="checkbox"/> Hospital outpatient <input type="radio"/> Hospital Inpatient <input type="radio"/> Physician Office for S2083
Primary Insurance Information	Name of Insurance Company: _____ Address: _____ _____ City, State, Zip: _____ _____ Phone: _____ Policyholder's Name: _____ Relationship to patient: _____ _____ Date of Birth: _____ Policy ID #: _____ Group Plan #: _____ Employers Name: _____ _____ Surgeon's participation with the insurer?: <input type="radio"/> Participating <input type="radio"/> Non-Participating
Secondary Insurance Information	Name of Insurance Company: _____ Address: _____ _____ City, State, Zip: _____ _____ Phone: _____ Policyholder's Name: _____ Relationship to patient: _____ Date of Birth: _____ Policy ID #: _____ Group Plan #: _____ Employers Name: _____ _____ Surgeon's participation with the insurer?: <input type="radio"/> Participating <input type="radio"/> Non-Participating