WORKSAFE TRAVAIL SÉCURITAIRE NB

Surgery Billing Form for WorkSafeNB Claimants

WorkSafeNB internal use only - Doc. Code AD

Claimant: _____ **Claim #:** _____

Medicare #: _____ **Date of Accident:** _____

Diagnosis: _____ **Part of the body:** _____

Physician: _____ **Payee #:** _____

Primary surgery ○	Surgical assistant GP ○	Surgical (assistant) specialist ○

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	☐ P ☐ 2S ☐ 2D					
3	☐ P ☐ 2S ☐ 2D					
4	☐ P ☐ 2S ☐ 2D					
5	☐ P ☐ 2S ☐ 2D					
6	☐ P ☐ 2S ☐ 2D					
7	Section 21 List Procedure					
8	Section 21 List Procedure					
9	BMI > 40 ☐ 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.

Revised February 2012