REQUEST FOR COST ESTIMATE

Estimate for:

Last name _____ First name _____

Address _____ City/Postcode/Country _____

Date of birth _____/_____/_____ ❑ female ❑ male

Any particulars re. Patient: _____

Cost estimate in ❑ German ❑ English

Surgeon _____

Diagnosis _____

Operation _____

ICD-10 _____ **CHOP** _____
(Classification-Code) (Treatment/Operation classification)

Duration of surgery _____ Duration of clinic stay / number of nights _____

Procedure covered by insurance ❑ yes ❑ no

Health insurance / accident insurance provider _____

Coverage ❑ General ❑ Semi-private ❑ Private
❑ Illness ❑ Accident (employer) ❑ Accident – insurance provider

Estimate requested for ❑ Single room ❑ Twin room ❑ Suite

Accompanying person/s _____ ❑ same room ❑ additional room/s _____

Following requirements:

❑ Arthroscope ❑ BV/C-arm ❑ Endoscope ❑ ENT –Video Tower

❑ Microscope ❑ Phaco ❑ Landmarx ❑ Ultracision (ultrasonic scalpel)

❑ Physiotherapy How many? _____ ❑ Laboratory/pathology testing _____

❑ Implant / make _____

❑ Miscellaneous_____

❑ Surgeon`s fee _____

❑ General anaesthetic ❑ Regional anaesthetic ❑ Local anaesthetic - monitored ❑ with re-positioning

Duration anaesthetic _____Anaesthetist's fee _____
(To be completed by anaesthetist)

❑ Estimate direct to patient (copy to surgeon)

❑ Estimate to surgeon ❑ Fax _____
❑ Email _____

Date_____/_____/_____ Signature _____

This form should be sent by email to: fakturation@pyramide.ch or by Fax to: + 41 44 388 16 15