Request for Price Quote or Estimate

CHOC or CCMH (please circle)

Patient Name: _____

Physician's Name: _____

Procedure Descr: _____

Est OR Time: _____

Date of Surg: _____

Cosmetic or Routine (please circle)

Inpt/Outpt/Pavilion (please circle)

Request Date: _____

ICD9: _____

CPT: _____

Requested by: _____

Phone # _____

Fax # _____

Please fax all price quote/estimate requests to the Revenue Audit Department (via this form) to 714-509-8753. All quotes/estimates are valid for 90 days. This quote/estimate is only for the facility portion of the bill and will not include pre-op testing, prosthetics, implants or binders. Estimates provided are strictly estimates; charges may be considerably higher/lower dependent upon what is ordered/utilized while services are being provided.

All requests will be processed within 24 hours of request receipt.

Date of Estimate: _____

Estimate/Quote: _____

Given to : _____

Provided by: _____

CHOC Revenue Audit, 505 S Main Street, Orange CA 92868
Phone: 714-289-4731 Fax 714-509-8753