

CENTRAL WYOMING OUTPATIENT SURGERY CENTER

Oral & Maxillofacial Procedures Delineation of Privileges

Applicant should mark an "X" in the "Requested" column corresponding to the clinical privilege requested.

Requested	Procedure	Approved	Denied
	Arthroscopic Surgery-TMJ		
	Bone Graft to the Jaw		
	Caldwell-Luc Procedure (foreign bodies)		
	Dentoalveolar Surgery		
	Dilatation and catheterization of salivary gland ducts		
	Fracture Reduction--closed and open		
	Fractured Jaw Wiring		
	Frenectomy with/without Graft from palate		
	Frenulectomy		
	Genioplasty		
	Implants to the jaw		
	Infections (oral)		
	Intraoral and lip biopsies and excisions		
	Intraoral and/or extraoral incision and drainage		
	Intraoral salivary gland surgery		
	Intraosseous benign tumors and cysts		
	Ligation of salivary gland duct surgery		
	Removal of benign tumors and cysts		
	Repair, oral and perioral soft tissue injuries, excluding complex and avulsion		
	Repair of anta-oral fistula		
	Repair of naso-oral fistula		
	Repair of fractures of the maxillofacial complex		
	Repair of zygomatic-maxillary complex fractures		
	Sequestrectomy and/or saucerization, jaws		
	Sialodochoplasty		
	Sialolithectomy		
	Suction lipectomy of facial regions		
	Surgical and theraputic treatment of second and third divisions of the Trigeminal Nerve		
	Trans-oral open reduction of fractures of the jaw		

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Requested	Procedure	Approved	Denied
<input type="checkbox"/>	Vestibuloplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other Procedures (please list):	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Physician Signature

Date

Medical Director Signature

Date

Central Wyoming Outpatient Surgery Center

MEDICARE ATTESTATION ACKNOWLEDGEMENT STATEMENT NOTICE TO PHYSICIANS

“Medicare payment to Ambulatory Surgery Centers is based on each patient’s procedures performed, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

I, _____, the undersigned, acknowledge having received the above notice.
(print or type name)

(legal signature)

(date)

(Legal signature means that which you would normally use on documents such as a Will, checks, etc. Initials are not acceptable.)