SURGICARE OF BROOKLYN

(347) 599-2100
(347) 599-2633
313 43rd Street, Brooklyn, NY 11232

SCOB, LLC
Delineation of Privileges for Podiatry Services

Applicant Name: ______________________________

Category: ☐ Initial Appointment ☐ Reappointment ☐ Other: ______________________

Procedure Name	Requested	Approved	Denied
Avulsion of Anil, Partial or Total, with or without Onychoplasty			
Closed Reduction of Digital Fracture with or without Splinting (No Internal Fixation)			
Hyfrecation, Curettage or Surical Excision of Verruca			
Incision and Drainage of Blister (Fore Foot Only)			
Incicion and Drainage of Superficial Abscess (Fore Foot Only)			
Removal of Fore Foot Lesions (Superficial and Non-Pigmented) or Superficial Foreign Body (Splinter, etc)			
Exostectomy, Osteotomy or Arthroplasty Lesser Metatarsals, Toes 2-5, with or without Internal Fixation			
Open or Closed Reduction of Lesser Metatarsal, Toes 2-5, Fractures Displaces in Non-Displaced Head or Shaft			
Osteotomy, Arthroplasty or Exostectomy Partial or Total, Toes 2-5			
Removal of Deep Fore Foot Lesions (Neuroma, Ganglion, Lipoma, Inclusion Cyst, or other Benign, Non-Pigmented Lesions)			
Tenotomy or Capsulotomy of Fore Foot Lesser Metatarsals, Toes 2-5			
1st. Metatarsal Osteotomy, Partial or total, with or without Internal Fixation			
Accessory Bone Removal of the Fore Foot			
Joint Fusion Procedures of the Fore Foot			
Joint Implantation of the Fore Foot - 1st Metatarsal Only, Toes 2-5			
Lisfranc Joint Subluxation (Closed Reduction Only)			
Removal of Any Other Soft Tissue Lesions of the Fore/Mid Foot			
Removal of Deep Foreign Body of the Fore Foot Removal of Exostoses or Ossicles of the Fore/Mid Foot			
Repair of Hallux Varus or Valgus			
Removal of Sesamoid or Sesamoid Planing			
Tenotomy and Capsulotomy of 1st MPJ			

Procedure Name	Requested	Approved	Denied
Excision and/or Plastic Repair of Soft Tissue Lesions of the Foot and Leg			
Excision of Plantar Fibromatosis			
Lisfranc Subluxation or Dislocation (Open Reduction with or without Internal Fixation)			
Rear Foot Capsulotoly or Arthroplastic Resection of Rear Foot Joints*			
Release or Resection of Plantar Fascia			
Removal of Accessory Bones of the Mid Foot or Rear Foot			
Repair or Bone Cysts or Excision of Bone Tumors			
Repair of Tendon Ruptures of the Rear Foot*			
Repair of Tendon Ruptures of the Fore Foot*			
Resection of Intra or Posterior Calcaneal Spurs			
Ankle Capsulotomy or Exeostectomy			
Arthrodesis of Rear Foot, Including Triple Arthrodesis*			
Closed Reduction and Casting of Non-Displaced Ankle Fractures			
Subtalar Joint Arthroereisis			
Ankle Arthroscopy*			
Other:			

Provider Acknowledgement: I have requested privileges marked in the above list. I certify that I have training and experience in performing these procedures and have never been denied or have never relinquished (voluntary or involuntary) privileges to perform these procedures at other institutions. I attest that I do not have any health issues which could impact my ability to perform the privileges I requested.

Signature of Requesting Provider: ______________________________ Date: ______________

RECOMMENDATION: I have reviewed the applicant's request for Podiatry Services and recommend that the requested privileges be approved and granted.

Medical Director Signature: ______________________________ Date: ______________

Board of Directors Confirmation by: ______________________________ Date: ______________