Basics of Coding and Billing for the Optometric Staff

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What is Coding
- A system of diagnosis and procedure codes to describe an encounter, procedure, diagnostic test, or supplies provided to a patient.
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)
- Manual is updated annually.
  - http://www.cms.hhs.gov/NationalCorrectCodInitEd/

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Vision Plan vs. Health Insurance
- Vision Plans
  - Coverage for routine wellness examinations
  - Some cover contact lens fitting services
  - May cover hardware
  - Contact lenses, frames and spectacles
  - Usually have a fixed amount that they contribute.
  - Some may only be discounted plans
  - Usage is typically limited to once/year
  - Frequently limit your coding ability

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Vision Plan vs. Health Insurance
- Health Insurance
  - Covers medical eye conditions
    - Office Visits
    - Diagnostic Testing
    - Office Procedures
      - May cover refractions?
  - Subject to co-payments and deductibles
  - Usually has few restrictions on number of office visits allowed.

Health Insurance
- Co-payment (Co-insurance)
  - Is the amount paid by the insured person each time a medical service is accessed
    - Sometimes this can be a fixed amount or a percentage of the allowed amount.
- Deductible
  - Portion of any claim that is not covered by the insurance provider.
  - The deductible must be paid by the insured, before the benefits of the policy can apply.
  - This payment should be collected from the patient at the time services are delivered.
  - Most office visits that have a fixed co-pay the deductible does not apply to the office visit only.
  - Most percentage based co-payments require a person must meet their deductible before any payment is made by the third party.
  - The deductible amount usually starts over each calendar year.

Coding Terminology
- Procedure codes
  - CPT-5
  - Current procedural Terminology, 5th Ed.
- Diagnosis Codes
  - ICD-9-CM
    - International Classification of Diseases, 9th Revision, Clinical Modifications
  - ICD-10 on October 1, 2013
- Material Codes
  - HCPCS
  - Health Care Procedures Coding System
- Pharmaceutical Codes
  - AHFS
    - American Hospital Formulary Service
Rules for billing

- The diagnosis (ICD-9-CM) must relate to the procedure (CPT) code
- Local Area Determination (LCD) will often tell you what ICD-9 code is allowed for a CPT code
- http://www.trailblazerhealth.com
- The doctor should code every patient
- The reason for the visit determines the coverage
  - Depends on the purpose of the examination rather than the ultimate diagnosis of the patient's condition

Best Practice Ideas

- Verify both health insurance and vision plan prior to every office visit.
  - Insurance plans frequently change
- Scan or copy image of insurance card and photo ID.
- Inform the patient what deductibles and co-pays will be collected prior to seeing the patient.

Clean Claim

- Simply one that the third party payer processes automatically without human review.
  - This is done through standard coding and using CPT and ICD-9
  - Most plans have a set period of time that you have to submit a clean claim from the date of service.

CPT (procedure) Code Categories

- 92000 Ophthalmology Codes
- 99000 Evaluation and Management Codes
- 60000 Surgical Codes
- 70000 Radiological Codes
- 80000 Laboratory Codes
Ways to Code Examinations

- S codes Routine Eye examinations
- 92000 Examination Codes
  - Special Ophthalmological Procedures
  - 99000 Evaluation and Management
- Consultations

What is a New Patient?

- A new patient is one who has not received any professional service from any doctor who belongs to the same group practice within 3 years.

Wellness Examination

- S codes are Level II HCPSC codes
- 50620 - New patient routine Ophthalmological examination with refraction
  - Texas Medicaid is one the first major payer to recognize this code.
- 50621 - Established patient routine Ophthalmological examination with refraction
  - Medicare does not reimburse for wellness exams
  - Many Vision plans have not yet adopted this code

General Ophthalmological Examination Codes

- Comprehensive Ophthalmological Exam
  - 92004 - New Patient
  - 92014 - Established patient

- Intermediate Ophthalmological Exam
  - 92014 - New Patient
  - 92012 - Established Patient

Comprehensive Ophthalmological Services (92004)

- A level of service in which a general evaluation of the complete visual system is made

- What’s required
  - History
  - General medical observation
  - External and internal Ophthalmoscopic examination
  - Gross visual fields
  - Basic sensory motor examination

- These definitions are not at strict as E/M codes
  - Please note Refraction is not included in this definition.

Intermediate Ophthalmological Services (92014)

- Describes a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
  - History
  - General medical observation
  - External ocular and adnexal examination
  - Other diagnostic procedures as indicated
  - May include the use of mydriasis
Evaluation and management codes

- E/M Codes can also be used to describe an eye examination
  - More and better documentation is required for the 99000 codes
  - Three components of E/M codes are
    - History
    - Examination
    - Decision making

- New Patient:
  - 99201, 99202, 99203, 99204, 99205

- Established Patient:
  - 99211, 99212, 99213, 99214, 99215

Evaluation and management codes

- History
  - Chief Complaint
    - A concise statement describing the symptoms, problem, condition, diagnosis, physician recommended referral, or other factor that is the reason for the encounter, usually stated in the patient's words.
    - Medical insurance also covers ongoing examinations or treatment for existing conditions.
  - History of present illness (HPI)
    - Is a chronological description of the development of the patient's present illness from the first sign or symptom
    - There are eight areas and two levels of a HPI history
      - 4 or more then you have a high level of history
      - Less than 4 elements then you have a brief HPI

E/M Coding: HPI Elements

<table>
<thead>
<tr>
<th>HPI Area</th>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>Location</td>
<td>Which eye has a problem?</td>
<td>Right; Left; Both</td>
</tr>
<tr>
<td>Quality</td>
<td>Does the problem cause?</td>
<td>Vision Loss or Blur</td>
</tr>
<tr>
<td>Context</td>
<td>Did the problem occur?</td>
<td>Sudden or gradually</td>
</tr>
<tr>
<td>Severity</td>
<td>How severe is the problem?</td>
<td>Mild, Moderate, Severe</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Is it worse at any distance?</td>
<td>Distance, Near, Both</td>
</tr>
<tr>
<td>Duration</td>
<td>How long does the problem last?</td>
<td>Intermittent, Constant</td>
</tr>
<tr>
<td>Timing</td>
<td>How long has the problem been present?</td>
<td>Short term, long term</td>
</tr>
<tr>
<td>Associated symptoms</td>
<td>Are there associated symptoms?</td>
<td>No, Headache, Nausea</td>
</tr>
</tbody>
</table>

Evaluation and management codes

- Review of Systems (ROS)
  - Review of systems has three levels
    - Review of one system = Problem Pertinent
    - Review of 2-9 systems = Extended ROS
    - Review of 10 or more systems = Complete ROS
    - It is not enough to make the statement "All systems Negative"

What are the Systems?

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin)
- Neurological
- Psychiatric
- Endocrine
- Hematological (blood)/Lymphatic
- Allergic/Immunological
Classification of History

<table>
<thead>
<tr>
<th>Type of History</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
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<tbody>
<tr>
<td>Problem focused</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

Examination Elements

- Visual Acuity
- Gross visual field testing by confrontation
- Ocular mobility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctiva
- Examination of ocular adnexa (area around the eye)
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus.
- Measurement of intraocular pressures
- Examination of pupils and irises including shape, direct and consensual reaction, size, and appearance.
- Ophthalmoscopic examination through dilated pupils of optic discs.
- Slit lamp examination of the anterior chambers, including depth, cells, and flare.
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film.
- Brief assessment of mental status including orientation to time, place, and person.

Evaluation and management codes

- **Examination**
  - Problem focused
    - 1-5 examination elements
  - Expanded problem focused
    - 6 or more examination elements
  - Detailed examination
    - 9 or more examination elements
  - Comprehensive examination
    - All elements

E&M: Medical Decision Making

<table>
<thead>
<tr>
<th>Type of decision making</th>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complication and/or morbidity or mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
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</tbody>
</table>

E & M coding: New Patient

- 3 Elements must be met or exceeded

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>Decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Problem Focused</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>99202</td>
<td>Expanded P.F.</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>99203</td>
<td>Detailed</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>99204</td>
<td>Comprehensive</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99205</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

E & M coding: Established Patient

- 2 Elements must be met or exceeded

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>Decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Focused</td>
<td>Straight Forward</td>
</tr>
<tr>
<td>99213</td>
<td>Expanded P.F.</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>
E&M Examples

- Established patient who has a comprehensive history and moderate decision making
  - 99215
- New patient has a comprehensive history, a detailed exam and straightforward medical decision making.
  - 99202
- An established patient has a comprehensive history, a detailed exam and straightforward medical decision making
  - 99214

Surgical codes

- You cannot bill for an office visit on the same day as a surgical code using the same diagnosis.
  - You can however bill if there is a significantly separate diagnosis for each procedure
- Surgical codes usually have a global period that includes follow up care.
  - Example: Punctal plugs = 10 days
  - The second procedure on the same day is always reimbursed at 50% of the allowed amount.

Special Ophthalmological Services

- Describes services in which a special evaluation of part of the visual system is made, which goes beyond the services included under general ophthalmological services.
  - 92015 Refraction
  - 92020 Gonioscopy
  - 92060 Sensorimotor
  - 92070 Fitting of contact lens for disease
  - 92225 Extended ophthalmoscopy
  - 92226 Subsequent ophthalmoscopy
  - 92082 Intermediate VF
  - 92140 Provocative Glaucoma test
  - 92250 Fundus Photography
  - 92283 Color Vision exam
  - 92285 External Photography
  - 92286 Specular Microscopy
  - 92287 Threshold VF
  - 92295 Retinal Photography
  - 92310 Carotid Doppler

Consultations

- A consultation is a type of service provided by a physician whose opinion or advice regarding E&M of a specific problem is requested by another physician or other appropriate source. There must be a report back to the requesting physician or other appropriate source.

- Three types of consultations codes
  - Office
    - 99241-99245
  - Initial inpatient
    - 99251-99255
  - Follow-up inpatient
    - 99261-99265

Consultation: Office 99241-99245

- These codes are used to report consultations provided in the physician’s office when another physician sends a patient to your office for a specific medical sign or symptoms.
  - You must have a written request from the physician requesting a consultation from you.
  - You must send a letter back to the referring physician
  - The consultation code can only be used on the first visit
  - Follow up visits in the consultant's office after the initial visits should be coded using established E&M coding.
  - CMS has eliminated the use of these codes as of Jan. 1, 2010.
  - Private insurance usually follows.

Modifier Codes

- Modifier Codes indicate unusual services, multiple procedures, surgical co-management, and break down procedures into their components.
  - 22 Greater than normal service
  - 25 Significant, separate identifiable E&M service by same provider on the same day
  - 26 Professional component
  - 50 Medical procedure
  - 51 Multiple procedures performed on the same day
  - 52 Reduced services
  - 55 Post operative management only
  - 58 Pre-operative management only
  - 59 Significant, separate identifiable procedure by same provider on the same day
  - TC Technical Component
  - RT Right
  - LT Left
  - RI Right Superior Eye Lid
  - RL Right Lower Eye Lid
  - LI Left Superior Eye Lid
  - LL Left Lower Eye Lid
  - GI Statutorily not covered by Medicare
Bilateral vs Unilateral

- Unilateral codes
  - Reimburse per eye
  - You could perform on just one eye
  - If you perform on both eyes you could use the modifier (50)
  - Better option is to list the procedure on two lines and indicate RT and LF
  - Example: Scanning Laser Ophthalmoscopy 92125

- Bilateral codes
  - Are designed to be performed on both eyes
  - If you only perform it on one eye then your such you a 52 modifier - reduced services to indicate only one eye
  - Example: Fundus Photos - 92250

- Unilateral or Bilateral
  - You would code it and be reimbursed the same if you perform the procedure on one or two eyes.
  - Example: Threshold Visual Field - 92083

Components

- Most diagnostic procedures can be broken down into their components using modifiers.
  - TC - Technical component.
    - Reimbursement the cost of the equipment
  - 26 - Professional component.
    - Reimburses the doctor’s interpretation of the data

- Without the modifiers then you receive both components

Diagnosis Codes: ICD-9-CM

- The first diagnosis code you list should be for the chief complaint that brought the patient into your office.
- Use the exact code for each diagnosis.
- Code the patient’s condition to the highest degree of certainty for that appointment.
- You may report treatments as many times as you provide them for the patient care at the time of the patient’s appointment.
- The appointment that brought the patient into your office.
- Always record a patient’s complaint in their words.
- Example: Blurred vision, eye pain, vision distortion
- Appointments should also be classified by type of service
- Comprehensive examination – Not RV

Diagnosis Codes: ICD-9-CM

- Codes are either 3,4,or 5 digits.
- 3 digit coding is very general
  - 373 = Inflammation of eyelids
- 4 digit coding increasing specificity
  - 373.0 = Blepharitis
- 5 digit coding is very specific
  - 373.01 = Ulcerative blepharitis

Best Practice Ideas

- Never record in a patient’s chief complaint that they are there for a “Routine eye exam” or “Needs new contacts/glasses”.
- Always record a patient’s complaint in their words.
- Example: Blurred vision, eye pain, vision distortion
- Appointments should also be classified by type of service
- Comprehensive examination – Not RV

Diagnosis Codes: ICD-9-CM

- Infections and parasitic diseases
  - 001-238.9
- Neoplasms
  - 140-239.9
- Endocrine, Nutritional, Metabolic, immunity disorders
  - 240-279.9
- Musculoskeletal System and connective tissue
  - 280-369.9
- Mental Disorders
  - 301-398.9
- Digestive System
  - 501-519.9
- Gastrointestinal System
  - 510-579.9
- Genitourinary System
  - 600-629.9
- Complications of Pregnancy, Childbirth and Puerperium
  - 630-679.9
- Injury and Poisoning
  - 800-999.9
ICD-9 V- Codes

- Classification is provided to deal with the occasions when circumstances other than a disease or injury classifiable to categories are recorded as "diagnoses" or "problems."
- When a person who is not sick encounters health services for a purpose
  - Organ or tissue donor
  - Prophylactic vaccination
  - Discuss a problem which is in itself not a problem
  - V65.5 Normal Exam
- When a person with a disease or injury encounters the health care system for treatment of that disease or injury
  - Dialysis for renal disease
  - Chemotherapy for malignancy
- When circumstances are present which influences the person’s health status but is not itself a current illness or injury.
  - V43.1 Pseudophakia
  - V67.51 Meds with Ocular toxicity

ICD-9 E Codes

- Classification system of environmental events, circumstances, and conditions as the case of injury
- Must be used in addition the diagnosis code
- E800-E999.9

HCPCS Material V-Codes

- Are also used to describe products optometrists dispense
  - V2020-V2025 Frames
  - V2100-V2499 Spectacle Lenses
  - V2500-V2599 Contact Lenses
  - V2600-V2615 Low Vision Devices
  - V2623-V2632 Surgical supplies
  - V2700-V2799 Spectacle Lens upgrades

Claim Submission

- CMS 1500 form
- Paper form
  - Mailed or faxed in
  - Medicaid requires that it must be typed and cannot be folded
- Web submission
  - Specific to a single payer usually
  - No special forms or accounts required
- Electronic clearing house
  - Submits claims in real-time to hundreds of insurance companies for payment.
  - Uses electronic Payer IDs

Cataract and Refraction

Foreign Body
Punctal Plugs

Routine Vision w/ Spectacles
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th><strong>MEDICARE</strong></th>
<th><strong>MEDICAID</strong></th>
<th><strong>TRICARE</strong></th>
<th><strong>CHAMPVA</strong></th>
<th><strong>GROUP HEALTH PLAN (SSN or ID)</strong></th>
<th><strong>FEDERAL BLACK LUNG (SSN or ID)</strong></th>
<th><strong>OTHER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Medicare #</td>
<td>[ ] Medicaid #</td>
<td>[ ] CHAMPUS (Sponsor's SSN)</td>
<td>(Member ID)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSURED'S I.D. NUMBER**

123456789

**INSURED'S NAME**

Doe John

**PATIENT'S ADDRESS**

123 Main Street

**CITY**

Austin

**STATE**

TX

**ZIP CODE**

78705-

**TELEPHONE**

972) 355-2800

**SIGNATURE ON FILE**

01/29/2010

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<table>
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<tr>
<th><strong>DATE OF CURRENT:</strong></th>
<th>01 29 10</th>
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<td><strong>ILLNESS:</strong> (First symptom) OR INJURY (Accident) OR PREGNANCY/LMP</td>
<td>365 01</td>
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<tr>
<td><strong>NAME OF REFERRING PROVIDER OR OTHER SOURCE:</strong></td>
<td>JONATHAN CARGO</td>
</tr>
<tr>
<td><strong>NPI:</strong></td>
<td>1134154206</td>
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<tr>
<td><strong>DATE(S) OF SERVICE:</strong></td>
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<tr>
<th><strong>PROCEDURES, SERVICES, OR SUPPLIES</strong></th>
<th><strong>DIAGNOSIS POINTERS</strong></th>
<th><strong>MODIFIER</strong></th>
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<tbody>
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<td>120.00 1</td>
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<td>76514</td>
<td>1</td>
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<td>92135 RT</td>
<td>1</td>
<td>50.00 1</td>
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<tr>
<td>92135 LT</td>
<td>1</td>
<td>50.00 1</td>
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<td>92083</td>
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<td>80.00 1</td>
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**SIGNATURE**

JONATHAN CARGO, O.D.

01 29 10

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</table>

**SIGNATURE DATE**

01 29 2010

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**MEDICARE - TRAILBLAZER HEALTH**

P.O. BOX 660031

DALLAS, TX 752660031

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**Please Print or Type**

Printed on Recycled Paper

**APPROVED OMB-0938-0999 FORM CMS-1500**

**STATE**

TX

**TELEPHONE**

972) 432-2020

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**MEDICAL BILLING INFORMATION & PHY:**

JONATHAN CARGO, O.D.

1335 Kinwest Pkwy, Suite 100

IRVING, TX 75063

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**SIGNATURE DATE**

01 29 2010
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>MEDICARE</td>
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<tr>
<td>2.</td>
<td>PATIENT'S NAME</td>
</tr>
<tr>
<td>3.</td>
<td>PATIENT'S BIRTH DATE</td>
</tr>
<tr>
<td>4.</td>
<td>INSURED'S NAME</td>
</tr>
<tr>
<td>5.</td>
<td>PATIENT'S ADDRESS</td>
</tr>
<tr>
<td>6.</td>
<td>PATIENT'S RELATIONSHIP TO INSURED</td>
</tr>
<tr>
<td>7.</td>
<td>INSURED'S ADDRESS</td>
</tr>
<tr>
<td>8.</td>
<td>PATIENT'S STATUS</td>
</tr>
<tr>
<td>9.</td>
<td>OTHER INSURED'S NAME</td>
</tr>
<tr>
<td>10.</td>
<td>IS PATIENT'S CONDITION RELATED TO:</td>
</tr>
<tr>
<td>11.</td>
<td>INSURER'S POLICY GROUP OR FEEA NUMBER</td>
</tr>
<tr>
<td>12.</td>
<td>PERSON'S AUTHORIZED PERSON'S SIGNATURE</td>
</tr>
<tr>
<td>13.</td>
<td>DATE OF CURRENT ILLNESS OR INJURY (First symptom or injury)</td>
</tr>
<tr>
<td>14.</td>
<td>NAME OF REFOERING PROVIDER OR OTHER SOURCE</td>
</tr>
<tr>
<td>15.</td>
<td>DATE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</td>
</tr>
<tr>
<td>16.</td>
<td>DATE(S) OF SERVICE</td>
</tr>
<tr>
<td>17.</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</td>
</tr>
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<td>18.</td>
<td>DIAGNOSIS POINTER</td>
</tr>
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<td>19.</td>
<td>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</td>
</tr>
<tr>
<td>20.</td>
<td>PLACE OF SERVICE</td>
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<td>CHARGES</td>
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<td>27.</td>
<td>ACCEPT ASSIGNMENT</td>
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<td>TOTAL CHARGE</td>
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<td>29.</td>
<td>AMOUNT PAID</td>
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</table>

**JONATHAN CARGO, O.D.**

**1135 Kinwest Pkwy, Suite 100**

**Irvings, TX 75056**

**1134154206**

**BCBS PPO**

**P.O. BOX 660044**

**DALLAS, TX 75266**
HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #:)
   1. MEDICAID (Medicaid #:)
   2. TRICARE (Sponsor's SSN)
   3. CHAMPUS (Member #:)
   4. CHAMPVA (Member #:)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   DOE JOHN

3. PATIENT'S BIRTH DATE
   03 13 1975

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
   (For Program in ID)
   123456789

5. PATIENT'S ADDRESS (No., Street)
   123 MAIN STREET

6. PATIENT'S ADDRESS (City, State, ZIP Code)
   AUSTIN, TX 78705

7. INSURED'S ADDRESS (No., Street)
   (City, State, ZIP Code)

8. PATIENT'S STATUS
   Single

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
   (Current or Previous)

10. IS PATIENT'S CONDITION RELATED TO:
    a. EMPLOYMENT?
    b. AUTO ACCIDENT?
    c. OTHER?

11. INSURED'S POLICY GROUP OR FECA NUMBER
    (Current or Previous)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary to
    process this claim. I also request payment of government benefits either to
    myself or to the party who accepts assignment below.

SIGNATURE ON FILE
01/29/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary to
    process this claim. I also request payment of government benefits either to
    myself or to the party who accepts assignment below.

SIGNATURE ON FILE
01/29/2010

14. DATE OF ILLNESS
    01 29 10

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
    GIVE FIRST DATE
    01 29 10

16. DATE PATIENT WAS UNABLE TO WORK IN CURRENT OCCUPATION
    FROM
    01 29 10

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    JONATHAN CARDO

18. HOSPITALIZATION DAYS RELATED TO CURRENT SERVICE
    FROM
    01 29 10

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?
    NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    366.16

22. MEDICAID RESUBMISSION NUMBER
    134154206

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
    01 29 10

25. FEDERAL TAX ID NUMBER
    061670230

26. PATIENT'S ACCOUNT NO.
    X

27. ACCEPT ASSIGNMENT?
    FOR GOVT. CLAIMS, SEE BACK
    YES

28. TOTAL CHARGE
    120.00

29. AMOUNT PAID
    40.00

30. BALANCE DUE
    80.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    JONATHAN CARDO, O.D.
    01 29 10

32. SERVICE FACILITY LOCATION INFORMATION
    134154206

33. BILLING PROVIDER INFO & PH #
    JONATHAN CARDO, O.D.
    134154206

JONATHAN CARDO, O.D.
1135 Kinwest Pkwy, Suite 1013
Irving, TX 75063

972 352-2011
### HEALTH INSURANCE CLAIM FORM

**MEDICAID- NHIC**
P.O. BOX 200555
AUSTIN, TX 78720-0555

**SIGNATURE ON FILE** 01/29/2010

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**FEDERAL TAX ID NUMBER** 061670320

**PATIENT'S ACCOUNT NO.** 19671

**TOTAL CHARGE** $650.00

**AMOUNT PAID** $650.00

**BALANCE DUE** $0.00

**JONATHAN CARGO, O.D.**

**01 29 2010**

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**31. SIGNATURE OF PHYSICIAN OR PROVIDER INCLUDING DEGREES OR CREDENTIALS**

**32. SERVICE FACILITY LOCATION INFORMATION**

---

**JONATHAN CARGO, O.D.**

01 29 2010