Ambulatory Surgery Center

Sample CMS - 1500 Paper Claim Form

Alcon Reimbursement Services
(866)457-0277

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AT-IOL
SAMPLE CLAIM FORM

Use for billing in ASC setting

PICA

1. MEDICARE [X] (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123-45-6789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, Jane N	3. PATIENT'S BIRTH DATE: 01 01 19XX; SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, Jane N	
5. PATIENT'S ADDRESS (No., Street): 123 Main Street	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street): 123 Main Street	
CITY: Anytown; STATE	8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
CITY: Anytown; STATE: USA	
ZIP CODE: 12345; TELEPHONE (Include Area Code): (203)555-1234	
ZIP CODE: 12345; TELEPHONE (Include Area Code): (203) 555-1234	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]
a. INSURED'S DATE OF BIRTH SEX: M [ ] F [ ]	
b. OTHER INSURED'S DATE OF BIRTH SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [ ]
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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. SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

14. DATE OF CURRENT: 01 01 2009 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE	CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 366.xx; 2. 367.2x (or 367.4 for presbyopia)	REF. NO.

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 31 12	07 31 12			66984	RT	1	XXX.XX			NPI	
2 07 31 12	07 31 12			V2787	GY	2	XX.XX			NPI	
3 07 31 12	07 31 12			V2788	GY	2	XX.XX			NPI	
4										NPI	
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PA	28. $	CE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. a. NPI b.	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

AcrySof® IQ Toric®

V2787 (Astigmatism correcting function of intraocular lens)

AcrySof® IQ ReSTOR®

V2788 (Presbyopia correcting function of intraocular lens)

Note regarding commercial payors: Some payors may not recognize code V2788 and may require another code for reporting non-covered services (eg: A9270, non-covered item or serviece)

Diagnosis pointer indicates astigmatism or presbyopia.

Modifier GY - (Item or service statutorily excluded or does not meet the definition of any Medicare benefit)

Non-covered charges - Facility charge for surgery with AT-IOL MINUS facility charge for surgery with conventional IOL EQUALS patient payment.

[1]www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf

Gray: required
Blue: if requested by the patient

Information contained in this document is provided as a reference for providers in obtaining appropriate and accurate reimbursement. Content within the document is for information purposes only. Alcon does not guarantee that the use of the recommended codes will result in reimbursement. Providers may always contact the payer directly in regards to any reimbursement or billing questions.

ARS
ALCON REIMBURSEMENT SERVICES

(866) 457-0277 - ARS@alconlabs.com

NOTE: CMS does not require non-covered services to be listed on the claim form. The code recommended above should be used if a patient requests a denial and/or for facility tracking of non-covered charges.[1]