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Optical Dispensing

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Reviewed and revised Nov. 2019

OPTICAL DISPENSING

INTRODUCTION

Challenges in coding are not limited to Evaluation and Management (E/M) documentation requirements, testing services or surgical coding. With the increasing number of ophthalmologists establishing optical dispensaries, knowledge of another range of codes and compliance is necessary.

HCPCS (pronounced "hick-picks") is the acronym for the Healthcare Common Procedure Coding System. The system provides a uniform method for health care providers to report professional services, procedures and supplies.

"V" codes in the HCPCS system are used to bill for frames and lenses. As coverage varies slightly by state, you should contact your Durable Medical Equipment Regional Carrier (DMERC) for your area's specifications.

DME Regions

Contracts were awarded to two Medicare Administrative Contractors (MACs) that break into four jurisdictions.

CGS Administrators:

- Jurisdiction B: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin
- Jurisdiction C: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia and West Virginia

Noridian Healthcare Solutions:

- Jurisdiction A: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont
- Jurisdiction D: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming

For up-to-date information, visit www.cms.gov/center/dme.asp

Medicare-Enrollment Requirements for Physician-Owned Optical Dispensary

Effective March 25, 2011, ophthalmologists and optometrists who supply Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), as well as postcataract optical services and who are newly enrolling or revalidating (every three years), are subject to a $500 enrollment fee. If you are currently enrolled in Medicare and the Provider Enrollment, Chain, and Ownership System (PECOS) and do not have to revalidate as a DMEPOS supplier, you will not see an immediate impact.

While the Centers for Medicare & Medicaid Services (CMS) place most physicians at the *lowest* level of risk, the agency puts all current or revalidating physicians who supply DMEPOS as part of their services (eg, physicians who provide) in the *moderate* level of risk. Newly enrolling DMEPOS suppliers will be placed in the *highest* level of risk, which includes fingerprinting, regardless of whether the supplier is a physician, or not.

What This Means

Low-risk providers (most physicians) are now subject to:

- Verification of any physician/supplier-specific requirements established by Medicare
- License verifications (may include licensure checks across states)
- Database checks to verify:
  - Social Security Number (SSN)
  - National Provider Identifier (NPI)
  - National Practitioner Databank (NPDB) information
  - Office of the Inspector General (OIG) exclusion
  - Taxpayer Identification Number (TIN)
  - Other information, such as recent deaths and other practice changes

Moderate-risk providers, (includes DMEPOS suppliers), are subject to the above, plus:

- Unscheduled or unannounced site visits
- $500 enrollment, adjusted annually based on the consumer price index

High-risk providers are subject to items listed above, plus:

- Fingerprint-based criminal-history record check of law enforcement repositories

CMS released a MLN Matters SE1417 stating that high-risk providers are those newly enrolled in DME. Other reasons for being listed as high-risk include:

- An imposed payment suspension within the last 10 years
- Exclusion from Medicare by the OIG
- Billing privileges were revoked by CMS within the previous 10 years
- Exclusion from any Federal Health Care program
- Subjected to any final adverse action, in the previous 10 years
- Termination or otherwise precluded from billing Medicaid

Practices must be enrolled in DME in order for a patient to use their postcataract benefit. If a patient purchases the glasses from a practice that is not enrolled, they will not be able to submit for reimbursement on their own. The application form, CMS 855S, can be found at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html. You can also enroll or revalidate with PECOS.

For any practice that fills a glasses prescription for a patient outside their practice, you must have a Surety Bond.

Advance Beneficiary Notice

The current version of the ABN has Exp. 03/2020 printed in the lower left-hand corner. All ABNs with the release date of 03/2011 that are issued on or after June 21,2017 will be considered invalid.

Key features of the ABN:

- It should only be used for Medicare Part B beneficiaries.
- It should be used for every beneficiary who is purchasing glasses or contact lenses, and all fields must be completed. Incomplete ABN will likely result in an overpayment request during an audit.
- It should be used when a patient has selected to purchase noncovered items. Most DMERC carriers list the HCPCS codes that are defined as noncovered in the Local Coverage Determination (LCD) policy regarding DMEPOS.
- It should be used if the practice suspects that they may have an issue getting paid for services rendered to Medicare Part B beneficiaries due to diagnosis and/or frequency of the service performed.

There are three options for the patient to choose:

Option 1. I want the services as outlined. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less copays or deductibles.

Note:

If a beneficiary is required to have an official decision from Medicare in order to file with the secondary policy they should select Option 1. When reviewing the ABN with the patient you are responsible for doing everything you can to clearly explain the transaction that is occurring.

Option 2. I want the services as outlined, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

Note:

This option allows a patient to receive item(s)/service(s) and pay for them out-of-pocket instead of having a claim submitted to Medicare.

Option 3. I don't want the services as outlined. I understand with the choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

The form has a mandatory field for:

- The optical shop name, address and phone number(s)
- the description of the service(s) provided
- reason(s) Medicare may not pay
- cost estimates of the items/services to be performed
- selection of provided option
- beneficiary signature and date

Medicare instructs physicians not to use general statements on the ABN. A statement, such as "Medicare may not pay," is too general and does not provide enough information to allow the beneficiary to make an informed decision about whether or not to proceed with the service.

Example of statement that is acceptable:

- Medicare Part B usually does not pay for this service.

The ABN is a Medicare approved form and cannot be altered, however there are specific fields of the ABN that can be customized ahead of time to

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

Figure 1 Sample ABN (English)

A. Notificante:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.**_____a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados.
Prevemos que Medicare no pagará **D.**_____a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D._____mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **OPCIÓN 1.** Quiero **D.**_____mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.**_____mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.
No tengo derecho a apelar si no se le cobra a Medicare.

☐ **OPCIÓN 3.** No quiero **D.**_____mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en un formato alternativo, por favor **llame al: 1-800-MEDICARE o escriba al correo electrónico**: AltFormatRequest@cms.hhs.gov.

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Formulario CMS-R-131 (Exp. 03/2020) Formulario aprobado OMB Nº 0938-0566

Figure 2 Sample ABN (Spanish)

accommodate for practice protocol and flow. The form is currently available in English and Spanish. Physicians/staff should document any translation assistance provided in the "Additional Information" section of the ABN.

Modifier -GA is still required on any claim submitted notifying Medicare Part B that the optical dispensary has an ABN on file and should be billed with the appropriate eye modifier.

It is required to review the ABN with the beneficiary in its entirety prior to the beneficiary signing the ABN.

All questions and concerns should be addressed prior to the signing of the ABN.

The ABN must be presented to the beneficiary far enough in advance to allow the beneficiary to make an informed decision and to consider all of the choices presented to them.

The patient name must appear listed on the ABN exactly as it appears on the patient's insurance card, including any middle initials.

The identification number of the patient may never be the Medicare numbers (HICNs) or SSN. Use your internal patient tracking number in this field.

The estimated cost should be listed as a general estimate that would typically be within 25 percent or $100 of the actual cost. Over-estimates are not concerning because the patient ultimately benefits from paying less than expected.

The ABN can be found at aao.org/abn.

MEDICARE COVERAGE FOR EYEGLASSES FOLLOWING CATARACT SURGERY

Pseudophakic Patients

Medicare Part B will pay for one complete pair of eyeglasses per eye surgery, unless cataract surgery is performed on both eyes at the same time (rarely done). In this case, Medicare Part B will pay for only one pair of eyeglasses. There is no time limit for the patient to use this benefit.

If a patient has a cataract extraction with intraocular lens (IOL) insertion in one eye, followed by a subsequent cataract extraction with IOL insertion in the other eye, and did not receive eyeglasses or contact lenses between the two surgical procedures, Medicare Part B will only cover one pair of eyeglasses or contact lenses after the second surgery. It would not be expected to see an order for glasses after the first eye knowing the second eye is already planned.

If the patient has a pair of eyeglasses, undergoes a cataract extraction with IOL insertion, and receives only new lenses but not new frames after the surgery, the benefit would not cover new frames at a later date (unless it follows subsequent cataract extraction in the other eye).

If the patient has cataract surgery on the right eye on June 1, they are eligible for one pair of eyeglasses. If the cataract in the left eye is removed on August 2, and the patient already filed for a pair of glasses after first surgery, the patient is eligible for another complete pair of eyeglasses.

The date of service is the date the glasses are ordered. Included on the claim form in box 19 is the date of surgery.

Medicare Part B will not pay for remakes or refinements of lenses owing to changes after surgery.

Tints (V2744), anti-reflective coating (V2750), or oversize lenses (V2780) are covered only when they are medically necessary for the individual patient and when the medical necessity is documented by the treating physician.

These items should be appended by modifier -KX and submitted on a separate claim.

Note:

If the supplier has obtained a physician's order for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items dispensed without a physician order.

Ultraviolet (UV) lenses (V2755) are considered reasonable and necessary following cataract extraction; therefore, additional medical necessity justification by the treating physician beyond inclusion on the order is not necessary.

Tinted lenses, used as sunglasses provided to an aphakic patient in addition to regular prosthetic lenses, will be denied as not medically necessary. Tinted lenses used as sunglasses prescribed to a pseudophakic patient in addition to regular prosthetic lenses will be denied as noncovered items.

Aphakic Patients

An aphakic patient is one who does not have an IOL implant, or who has a congenital absence of the lens.

For aphakic patients, the following lenses or combinations of lenses are covered when determined to be medically necessary:

- Bifocal lenses in frames
- Lenses in frames for far vision and lenses in frames for near vision
- When contact lenses for far vision are prescribed, (including cases of binocular and monocular aphakia), payment will be made for the contact lenses, and lenses in frames for near vision to be worn at the same time as the contact lenses, and lenses in frames to be worn when the contacts have been removed.

When medically necessary, Medicare Part B will cover replacement of lenses.

Eyeglasses are covered even though the surgical removal of the natural lens occurred before Medicare entitlement.

Scratch resistant coating (V2760) and transition/progressive lenses (V2781) are noncovered as deluxe items.

Only standard frames (V2020) are covered. Additional charges for deluxe frames (V2025) are noncovered.

Diagnosis Codes

Covered diagnoses are limited to:

Pseudophakia	ICD-10 Z96.1. ICD-10 codes for supporting documentation Z98.41, Z98.42
Aphakia	ICD-10 H27.01, H27.02, H27.03
Congenital aphakia	ICD-10 Q12.3

Lenses provided for other diagnoses will be denied as noncovered items.

Patient Payment and Explanation of Medical Benefits

The Remittance Advice (RA) form details data that patients receive when they order any luxury eye wear. In the following example, dollar amounts are for instructional purposes only.

JUNE 1, 2002		BILLED	APPROVED
V2020	Frame	$100.00	$80.00
V2203	Bifocals	$ 70.00	$45.00
V2799	High index	$ 65.00	$ 0.00

For the June 1 example, determine whether the optical department will or will not accept assignment. Best practice is to verify that an ABN was obtained for noncovered materials, as this will determine the amount you collect from the patient. Clearly explained patient financial responsibility can allow you to collect up front.

Billing patients, instead of collecting money up front, will render an optical shop cash-poor quickly and should be avoided. Many offices have a simple, direct statement printed on their receipts: "Any balance remaining after insurance payments are received is the patient's responsibility."

HCPCS V CODES

Codes listed in this section do not necessarily indicate insurance coverage.

Frames

V2020 Frames, purchases

V2025 Deluxe frame

Spectacle Lenses

V2100 Sphere, single vision, plano to plus or minus 4.00, per lens

V2101 Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens

V2102 Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens

V2103 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens

V2104 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens

V2105 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens

V2106 Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder per lens

V2107 Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens

V2108 Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens

V2109 Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens

V2110 Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens

V2111 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens

V2112 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens

V2113 Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens

V2114 Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens

V2115 Lenticular, per lens, single vision

V2118 Aniseikonic lens, single vision

V2199 Not otherwise classified, single vision lens

V2200 Sphere, bifocal, plano to plus or minus 4.00d, per lens

V2201 Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2202 Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
V2203 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2204 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2205 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2206 Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2207 Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2208 Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2209 Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2210 Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2211 Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2212 Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2213 Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2214 Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
V2215 Lenticular, per lens, bifocal
V2218 Aniseikonic, per lens, bifocal
V2219 Bifocal seg width over 28 mm
V2220 Bifocal add over 3.25d
V2299 Specialty bifocal (by report)
V2300 Sphere, trifocal, plano to plus or minus 4.00d, per lens
V2301 Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2302 Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
V2303 Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2304 Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens
V2305 Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2306 Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2307 Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2308 Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2309 Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2310 Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2311 Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2312 Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2313 Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2314 Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
V2315 Lenticular, per lens, trifocal
V2318 Aniseikonic lens, trifocal
V2319 Trifocal seg width over 28 mm
V2320 Trifocal add over 3.25d
V2399 Specialty trifocal (by report)
V2410 Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430 Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499 Variable sphericity lens, other type

Vision Aids

The following are paid according to insurance carrier discretion. Medically necessary documentation may be required from the prescribing physician.

V2600 Hand held low vision aids and other nonspectacle mounted aids
V2610 Single lens spectacle mounted low vision aids

V2615 Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes, and compound microscopic lens system

Miscellaneous V Codes

V2700 Balance lens, per lens
V2710 Slab off prism, glass or plastic, per lens
V2715 Prism, per lens
V2718 Press-on lens, Fresnel prism, per lens
V2730 Special base curve, glass or plastic, per lens
V2744 Tint, photochromatic, per lens
Used for any type of photochromatic lens, either glass or plastic
V2745 Any tint, excluding photochromatic
V2750 Anti-reflective coating, per lens
V2755 UV lens, per lens
V2760 Scratch resistant coating, per lens
V2761 Mirror coating
V2770 Occluder lens, per lens
V2780 Oversize lens, per lens
V2781 Progressive lens, per lens
This is a multifocal lens that gradually changes in lens power from the top to the bottom of the lens, eliminating the line(s) that would otherwise be seen in a bifocal or trifocal lens. Used for the difference in price between the standard lens and progressive. Medicare will deny this code.
V2782 High index. Can't be added to V2784
V2783 High index. Can't be added to V2784
V2784 Poly and Trivex
V2799 Vision service, miscellaneous, such as high index, including glass, plastic, bifocal, and trifocal, and should be used as an add-on code to existing billing.
V5160 Dispensing fee
Polycarbonate, polarized, including bifocal and trifocal, should be used as an add-on code to existing billing.

CODING AND DOCUMENTATION GUIDELINES

Coding Guidelines

The -RT (right eye) and -LT (left eye) modifiers must be used with all HCPCS codes except V2020, V2025 and V2600.

When lenses are provided bilaterally and the same code is used for both lenses, bill both lenses on the same claim line using the -RT/-LT modifier and two units of service.

Codes V2100–V2218, V2299–V2318, V2399–V2499, V2700 and V2770 describe specific eyeglass lenses. Only one of these codes may be billed for each lens provided.

Codes V2219, V2220, V2319, V2320, V2710–V2760 and V2781 describe add-on features of lenses. They are billed in addition to codes for the basic lens.

Note:

Fresnell press-on prisms may be a covered benefit when appending modifier -KX to V2718. However, billing for press-on prisms may impact payment for ground-in prism coverage due to utilization. Best practice is to obtain an ABN and append modifier -GA as well as -KX.

When billing claims for deluxe frames, use code V2020 for the cost of standard frames and a second line item using code V2025 for the difference between the charge for the deluxe frames and the standard frames.

When billing claims for progressive lens, use the appropriate code for the standard bifocal (V2200–V2299) or trifocal (V2300–V2399) lens and a second line item using code V2781 for the difference between the charge for the progressive lens and the standard lens.

Modifiers

-EY Used for anti-reflective, tints, oversize lens or polycarbonate not ordered by a provider.
Since NPI implementation in May 2008, any line items with -EY must be on a separate claim.
-KX Documentation to support medical necessity.
Use for anti-reflective coating, tints, and oversize lenses if ordered by provider.
Use for polycarbonate lenses if ordered by provider (usually for monocular vision)
To read the OIG report Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment (A-04-10-04004), dated April 2012, visit http://oig.hhs.gov/oas/reports/region4/41004004.pdf
-GA Item or service expected to be denied as not reasonable and necessary; ABN on file
-RT Right side
-LT Left side

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be

necessary in order to determine the amounts due such provider" (42 U.S.C. § 1395l[e]). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports. This documentation must be available to the DMERC upon request.

The medical record must contain a detailed order for the post-cataract glasses or contact lenses (for aphakia) and must clearly state an order for the patient's frame. The order must include the diagnosis code and/or a narrative diagnosis for the condition necessitating the lens(es) and frame, and must be signed by the treating physician and kept on file by the supplier. For those providers who are both ordering physician and supplier, the prescription is an integral part of the patient's record. All submitted claims must include the diagnosis code relating to the need for the item.

A detailed written order (DWO) for the lens(es), including frames, that has been signed and dated by the treating physician must be kept on file by the supplier.

DWO must include:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items). It should include the diagnosis code and/or a narrative diagnosis for the condition necessitating the lens(es).
- Physician signature and signature date

All claims must include the diagnosis code relating to the need for the item.

If aphakia is the result of the removal of a previously implanted lens, the date of the surgical removal of the lens must accompany the claim.

When billing for glasses, the place of service (POS) is 12. A copy of any ABN given to/signed by the patient must be retained in the patient record.

CMS has an LCD policy, L33793, providing guidance for billing purposes. It is recommended to print out the policy and frequently check back to see if it has been updated. The policy can be found at www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33793&ContrId=140&ver=9&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&bc=AgACAAIAAAAAAA%3d%3d&ME-LCD

CMS also has a coverage article for refractive lenses A52499, which can be found at www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52499&ContrID=140

Patient Receipt of Glasses and Proof of Delivery

Documentation that the patient has received the postcataract eyeglasses must be maintained. The delivery date is the date that the beneficiary or an authorized representative actually picks up the glasses, or the date that the package was shipped in the event of having to mail or use a delivery service. The delivery date is used as the date of service on the claim form.

The Proof of Delivery must be kept on file for seven years, and should include a detailed list of the items being purchased by the Beneficiary. There are three methods of delivery for post-cataract glasses and contact lenses:

- Patient or authorized representative is directly receiving the Item(s) at the optical shop
- The Item(s) are being delivered by either mail service or delivery service
- The Item(s) are being delivered to a nursing facility on behalf of the patient

Beneficiaries should receive a copy of the Proof of Delivery at the time they pick up their glasses or contact lenses. Check with your local DMERC and LCDs for specifications on Proof of Delivery.

Remember that post-cataract glasses cannot be dispensed while the patient is in a skilled nursing facility (SNF).

Optical Evaluation Assessment

Many offices find that a patient questionnaire is helpful in identifying patients' optical needs.

The majority of your day is spent:

Outdoors/driving	Recommend: Sunglasses, transitional or polarized lenses
Sports/yard work/ carpentry	Recommend: Protective eyewear
Computer or desk work	Recommend: Single vision lenses
Sewing	Recommend: Single vision lenses
Bothered by glare from: • Sun when driving • Computer screens • Fluorescent lights • Headlights at night	Recommend: Anti-reflective coating

Contact Lens Coding

Codes for contact lens fitting, refitting, replacement and modification are available in two coding divisions: Level I CPT and HCPCS. Code selection depends upon the insurance carrier's requirements.

Level I CPT Codes

The description of "prescription" as identified in CPT codes 92310–92317 includes:

- Specifications of the contact lens including base curve, power, diameter and polymer
- Instruction concerning lens care and training on lens insertion and removal

CPT codes 92310–92317 are not bundled with the E/M or Eye visit code examinations or with code 92015 Determination of refractive state.

Supplying the contact lens may be reported as part of the code. If supply of the contact lens is not included, append modifier -26, indicating that the professional component of the code was provided and not the actual supply of the lens.

Subsequent or follow-up visits should be reported with the appropriate E/M or Eye visit code.

92310 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia

For prescription and fitting of one eye, append modifier -52 showing a reduced service; payment will be affected.

92311 corneal lens for aphakia, one eye

92312 corneal lens for aphakia, both eyes

92313 corneoscleral lens

At one time there were lenses that actually covered the sclera encapsulating the entire eye.

Rarely used today.

92314 Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia

For prescription and fitting of one eye, append modifier -52 showing a reduced service; payment will be affected.

92315 corneal lens for aphakia, one eye

92316 corneal lens for aphakia, both eyes

92317 corneoscleral lens

92325 Modification of contact lens (separate procedure), with medical supervision of adaptation

92326 Replacement of contact lens

Tip: Medicare will only pay for soft contact lenses for patients who are Aphakic and have recently had cataract surgery. Post-cataract surgery modifiers will still apply and should be added appropriately and dates of surgery should be included on the claim in the appropriate field.

From CPT Assistant Archive—Coding for Ophthalmological Services

Coding for Contact Lens Services

The prescription of contact lenses includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is not a part of the general ophthalmological services.

The fitting of contact lenses includes instruction and training of the wearer and incidental revision of the lenses during the training period. Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012 et seq).

As indicated earlier, the prescription of contact lenses is not part of the general ophthalmological services. Therefore, the prescription of contact lenses may be reported separately in addition to the general ophthalmological service codes and E/M if performed. If a patient presents for follow-up of successfully fitted extended wear lenses, this is part of the general ophthalmological services using 92012 and 92014, and is not a separately reportable service.

Coding for Spectacle Services (Including Prosthesis for Aphakia)

During determination of the refractive state, the physician examines the patient for refractive error. Some common types of refractive errors are hyperopia (farsightedness), astigmatism, and myopia (nearsightedness). The physician may prescribe corrective lenses to help relieve the symptoms caused by refractive error. As the prescription of lens is included in the determination of the refractive state, it would not be reported separately. However, the fitting of the spectacles themselves is a separately reportable service when performed by the physician and would be reported by using codes 92340, 92341, 92342, 92352, 92353, 92354, 92355, 92358, 92370, 92371.

Prescription of lenses, when required, is included in 92015, Determination of refractive state. It includes specification of lens type (monofocal, bifocal, other), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

Fitting includes measurement of anatomical facial characteristics, writing of laboratory specifications, and final adjustment of the spectacles to the visual axis and anatomical topography. The presence of a physician is not required. Supply of materials is a separate service component; it is not part of the service of fitting spectacles.

HCPCS Codes

Insurance carrier payment policy for each contact code is subject to quantity alert and carrier discretion.

V2500 Contact lens, PMMA, spherical, per lens
V2501 Contact lens, PMMA, toric or prism ballast, per lens
V2502 Contact lens, PMMA, bifocal, per lens
V2503 Contact lens, PMMA, color vision deficiency, per lens
V2510 Contact lens, gas permeable, spherical, per lens
V2511 Contact lens, gas permeable, toric, prism ballast, per lens
V2512 Contact lens, gas permeable, bifocal, per lens
V2513 Contact lens, gas permeable, extended wear, per lens
V2520 Contact lens, hydrophilic, spherical, per lens
Covered by Medicare only for aphakic patients
V2521 Contact lens, hydrophilic, toric, or prism ballast, per lens
Covered by Medicare only for aphakic patients
V2522 Contact lens, hydrophilic, bifocal, per lens
Covered by Medicare only for aphakic patients
V2523 Contact lens, hydrophilic, extended wear, per lens
Covered by Medicare only for aphakic patients
V2530 Contact lens, scleral, gas impermeable, per lens
V2599 Contact lens, other type

Medicare covers plastic polymer contact lenses for aphakic patients.

B02.33 Zoster keratitis (Herpes zoster keratoconjunctivitis)
B00.52 Herpesviral keratitis (Herpesviral keratoconjunctivitis)
G51.0 Bell's palsy (Facial palsy)
H44.421 Hypotony of right eye due to ocular fistula
H44.422 Hypotony of left eye due to ocular fistula
H44.423 Hypotony of eye due to ocular fistula, bilateral
H44.411 Flat anterior chamber hypotony of right eye
H44.412 Flat anterior chamber hypotony of left eye
H44.413 Flat anterior chamber hypotony, bilateral

Bandage Contact Lens

CPT 2012 introduced two new codes to replace 92070 Fitting of contact lens for treatment of disease including supply of lens. One code was for a bandage contact lens fitting, and the second code was for keratoconus lens fitting.

- CPT code 92071 Fitting of contact lens for treatment of ocular surface disease.
- Bundled with 92072 Fitting of contact lens for management of keratoconus; initial, and exam code 99211.
- Payable per eye. Submit with modifiers -RT or -LT or modifier -50.
- Report supply of special order lens separately.

Options for supply of lens:

CPT CODE 99070	Supply of lens	May require an invoice
CPT CODE 92326	Replacement of contact lens	
HCPCS CODE V2599	Contact lens, other type	Commercial payers may not recognize HCPCS code

Coverage issues:

- Practice may not be a supplier of durable medical equipment.
- HCPCS code may not be recognized.
- Diagnosis codes are not a covered benefit.
- Patient is likely to be responsible for payment.

Keratoconus Contact Lens

CPT code 92072 Fitting of contact lens for management of keratoconus; initial

- Payment is inherently bilateral.
- Bundled with exam code 99211 and 92071 Bandage contact lens fitting.
- For subsequent fittings, report using E/M or Eye visit code services.

Options for supply of lens:

CPT Codes

99070 Supply code—May require an invoice
92326 Replacement of contact lens

HCPCS Codes

V2500 PMMA, spherical, per lens
V2501 PMMA, toric or prism ballast, per lens
V2502 PMMA, bifocal, per lens
V2510 Gas permeable, spherical, per lens
V2511 Gas permeable, toric, prism ballast, per lens
V2512 Gas permeable, bifocal, per lens

V2513	Gas permeable, extended wear, per lens
V2530	Scleral, gas impermeable, per lens
V2531	Gas permeable, per lens
V2599	Other, type

Coverage issues:

- Practice may not be a supplier of durable medical equipment.
- HCPCS code may not be recognized.
- Diagnosis codes are not a covered benefit.
- Some payers may require a prior approval and may even request a copy of the invoice.
- Patient is likely to be responsible for payment.

Contact Lens Solutions

Contact lens cleaning solution and normal saline for contact lenses are not covered by insurance plans but may be billed using CPT code 99070, Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered. Many states require charging sales tax for these items.

Typical Covered Diagnosis Codes

H04.121, H04.122, H04.123	Dry eye syndrome of lacrimal gland (Tear film insufficiency, NOS)
H16.011, H16.012, H16.013	Central corneal ulcer
H16.021, H16.022, H16.023	Ring corneal ulcer
H16.031, H16.032, H16.033	Corneal ulcer with hypopyon
H16.041, H16.042, H16.043	Marginal corneal ulcer
H16.051, H16.052, H16.053	Mooren's corneal ulcer
H16.061, H16.062, H16.063	Mycotic corneal ulcer
H16.071, H16.072, H16.073	Perforated corneal ulcer
H16.111, H16.112, H16.113	Macular keratitis (Areolar, Nummular, Stellate, Striate keratitis)
H16.121, H16.122, H16.123	Filamentary keratitis
H16.141, H16.142, H16.143	Punctate keratitis
H16.211, H16.212, H16.213	Exposure keratoconjunctivitis
H16.221, H16.222, H16.223	Keratoconjunctivitis sicca, not specified as Sjogren's
H16.231, H16.232, H16.233	Neurotrophic keratoconjunctivitis
H18.11, H18.12, H18.13	Bullous keratopathy
H18.421, H18.422, H18.423	Band keratopathy
H18.51	Endothelial corneal dystrophy (Fuchs' dystrophy)
H18.59	Other hereditary corneal dystrophies
H18.621, H18.622, H18.623	Keratoconus, unstable (Acute hydrops)
H18.731, H18.732, H18.733	Descemetocele
H18.831, H18.832, H18.833	Recurrent erosion of cornea
M35.01	Sicca syndrome [Sjogren] with keratoconjunctivitis, Excludes1: reactive perforating collagenosis (L87.1)
S05.01X-, S05.02X-	Injury of conjunctiva and corneal abrasion without foreign body—Add 7th final character A, D or S
S05.31X-, S0532X-	Ocular laceration without prolapse or loss of intraocular tissue—Add 7th final character A, D or S
T15.01X-, T15.02X-	Foreign body in cornea—Add 7th final character A, D or S
T26.11X-, T26.12X-	Burn of cornea and conjunctival sac—Add 7th final character A, D or S
T26.61X-, T26.62X-	Corrosion of cornea and conjunctival sac—Add 7th final character A, D or S
Z94.7	Corneal transplant status

MEDICARE ADVANTAGE PLANS

While Medicare Part B has limited coverage benefits, Medicare Advantage plans may offer additional covered services for their beneficiaries. They are administered by third party payers, who often contract with vision plans as a member benefit.

- Routine eye exams: May limit what diagnoses can be submitted. Exams may be as frequent as once per year.
- Glasses, frames and/or contact lenses: Plans may offer one pair every 24 months.

Be sure to confirm with the payer prior to providing services as each plan will vary in offerings.

Optical Company, LLC

PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: _____ Date of Birth: _____

Delivery Address: _____

City: _____ State: _____ Zip Code: _____-_____

Delivery Date: _____

Description of Pseudophakic/Aphakic Glasses:

Optician: _____

FRAME MODEL: _____

LENS TYPE: _____

MATERIAL: _____

CASE: _____

LENS CARE KIT: _____

QUANTITY: _____

METHOD OF DELIVERY – SELECT ONE:

1. Patient or authorized representative is directly receiving item(s) at one of the above locations*
2. The item(s) above are being delivered by either mail service or delivery service **
3. The item(s) listed above are being delivered to a nursing facility on behalf of the patient ***

** An authorized representative is "a person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary." – Per DME MAC Jurisdiction C Supplier Manual*
*** If item is being shipped, complete additional shipping form and attach to this POD.*
**** If item is being delivered to a nursing facility, complete additional facility form and attach to this POD.*

PROOF OF DELIVERY: This is confirmation that I have received the item(s) listed above:

_____ _____
Signature of Patient or Patient Representative Date

If Patient Representative, please indicate relationship to patient: _____

*****Please see reverse side of this document for Care of Lenses and Frames and Complaint Resolution Protocol***

This product(s) and/or service(s) provided to you by Optical Company, LLC are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gov. Upon request it will be our pleasure to furnish you a written copy of the standards.

Figure 3 Sample Proof of Delivery

Optical Company, LLC

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

CARE OF LENSES AND FRAMES:

- Use a clean, soft cloth designed to clean eyeglasses. Our Optical Shop has provided you with an initial cleaning cloth in your Lens Care Kit.
- Avoid using tissues or clothing – this may scratch and/or damage your lenses.
- Use approved eyeglass cleaner (like the one provided in your Lens Care Kit) or a mild detergent with warm water to clean frames and lenses.
- **DO NOT SLEEP IN YOUR GLASSES.**
- Use your eyeglass case when not in use to avoid damages.

COMPLAINT RESOLUTION PROTOCOL:

- For issues regarding your eyeglasses, please contact the Optical Department at the phone numbers listed above. We advise you to contact the office where you ordered your glasses; however for your convenience any of our staff will be able to assist you at either location.
- You may be asked to schedule a follow-up appointment with the physician to determine changes with your eyeglasses prior to any changes, exchange, or refund.
- Warranty or exchange policy may be found in the "About Your Eyeglasses" brochure you received when your order for your glasses was placed.
- You may contact the Optical Manager or Practice Manager for unresolved issues.

Figure 3 Sample Proof of Delivery *(continued)*

Optical Company, LLC
DELIVERY VIA SHIPPING or DELIVERY SERVICE
PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: _____ Date of Birth: _____

[Attach all necessary documentation to the back of this form and leave no field blank]

1. Is the item being shipped or is a delivery service being used? _____
2. What is the name of the shipping or delivery service being used?
   _____
3. **What is the delivery address**:
   _____
   Address
   _____ _____ _____
   City State Zip
4. What is the Optical Company Invoice Number? _____
5. What is the tracking number for the delivery? (only complete one)
   CERTIFIED MAIL TRACKING NUMBER: _____
   OVERNIGHT MAIL TRACKING NUMBER: _____
   DELIVERY SERVICE TRACKING NUMBER: _____
6. What item is being shipped:
   FRAME MODEL: _____
   LENS TYPE: _____
   MATERIAL: _____
   CASE: _____
   LENS CARE KIT: _____
   QUANTITY: _____
7. What is the date the item is being shipped? _____
   NOTE: THIS SHIPPING DATE MUST BE THE SERVICE DATE ON YOUR ROUTER

Return receipt requests (i.e., packages requiring a signature) is mandatory for all shipping of items.

Attach the return receipt with patient signature to the back of this form, along with a copy of the invoice from the lab.

OPTICIAN COMPLETING FORM AND SHIPPING ITEM: _____
Signature: _____ Date: _____

Figure 4 Sample Proof of Delivery for Shipping Glasses to Beneficiary

Optical Company, LLC

DELIVERY TO NURSING FACILITY ON BEHALF OF A BENEFICIARY
PROOF OF DELIVERY

1234 Front Street, San Francisco CA 94109
Phone: (999) 987-6543

655 Beach Street, San Francisco CA 94109
Phone: (999) 987-3456

Patient Name: _____ Date of Birth: _____

[Attach all necessary documentation to the back of this form and leave no field blank.
You must provide a copy of the completed form to the Nursing Facility prior to leaving]

1. What is the name of the Nursing Facility? _____
2. What is the address/destination of the Nursing Facility?

   _____
   Address

   _____ _____ _____
   City State Zip

3. What is the Optical Company Invoice Number? _____
4. What item is being delivered:
   FRAME MODEL: _____
   LENS TYPE: _____
   MATERIAL: _____
   CASE: _____
   LENS CARE KIT: _____
   QUANTITY: _____
5. What is the date the item is being delivered? _____
   NOTE: THIS DELIVERY DATE MUST BE THE SERVICE DATE ON YOUR ROUTER

I acknowledge that I have received the above items for the above named beneficiary, _____ and will present them to the beneficiary immediately.

_____ _____
Nursing Facility Representative (print) Signature

Title: _____ Date: _____

Name of Optician Delivering Items to Nursing Facility: _____

Signature: _____ Date: _____

Figure 5 Sample Proof of Delivery to a Nursing Home

Optical Company, LLC

POST-CATARACT GLASSES ITEMIZED ROUTER

The Optician serving you for this transaction is: _____

1234 Front Street, CA 94109 (999) 978-6543 655 Beach Street, CA 94109 (999) 978-3456

Beneficiary Name: _____ Identification Number: _____

Code	Modifier	Description	Medicare Allowable	Patient Responsibility	Non-Covered Patient Responsibility	Sales Tax
V2020		Frame (Base Medicare Allowable)				
V2025	GA	Deluxe Frame				
V_____	KXRT	Right Lens Surgery Date: _____				
V_____	KXLT	Left Lens Surgery Date: _____				
V2755	KXRT	UV Applied By Lab				
V2755	KXLT	UV Applied By Lab				
V2781	GART	Progressive Lens Overage				
V2781	GALT	Progressive Lens Overage				
V2760	GART	SRC TD2 or Carat Advantage				
V2760	GALT	SRC TD2 or Carat Advantage				
V2____	GART	Lens Feature:				
V2____	GALT	Lens Feature:				
V2____	GART	Lens Feature:				
V2____	GALT	Lens Feature:				
V2____	GART	Lens Feature:				
V2____	GALT	Lens Feature:				
		Total Each Column:	$	$	$	$

Ordering Physician

Dr. John

Dr. Smith

Dr. Williams

Total Charges: $_____

Total Due from Patient: $_____

Total Payment Received: $_____

Balance Due (if any): $_____

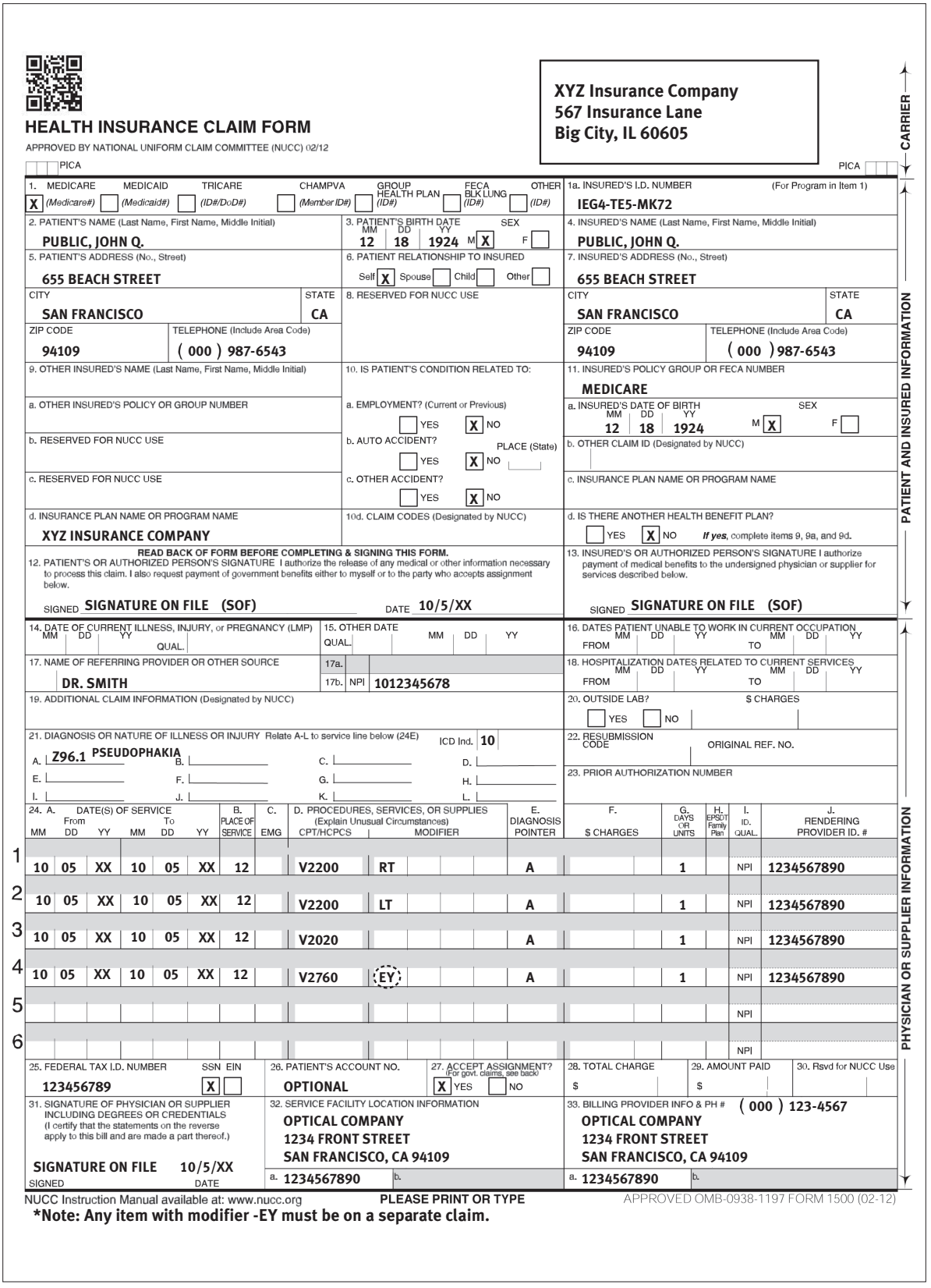
Method of Payment Received:

Cash Check#_____

VS MC AMEX DISC

I, _____ understand that Medicare pays 80% of allowed charges. Medicare Replacement Plans and Supplemental Insurance will be filed and it will be the patient's responsibility for any and all charges not paid by insurance.
All deductibles, co-pays, and non-covered services are the patient's **responsibility.**

Figure 6 Sample Optical DMERC Router



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

XYZ Insurance Company
567 Insurance Lane
Big City, IL 60605

CARRIER

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN Q.	3. PATIENT'S BIRTH DATE: 12 / 18 / 1924 SEX: M [X] F [ ]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN Q.
5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET
CITY: SAN FRANCISCO STATE: CA	8. RESERVED FOR NUCC USE	CITY: SAN FRANCISCO STATE: CA
ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543		ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543
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: MEDICARE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH: 12 / 18 / 1924 SEX: M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ INSURANCE COMPANY	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.
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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX		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: SIGNATURE ON FILE (SOF)
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH	17a. 17b. NPI 1012345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

	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	10 05 XX 10 05 XX	12		V2200	RT	A		1		NPI	1234567890
2	10 05 XX 10 05 XX	12		V2200	LT	A		1		NPI	1234567890
3	10 05 XX 10 05 XX	12		V2020		A		1		NPI	1234567890
4	10 05 XX 10 05 XX	12		V2760	EY	A		1		NPI	1234567890
5										NPI	
6										NPI	

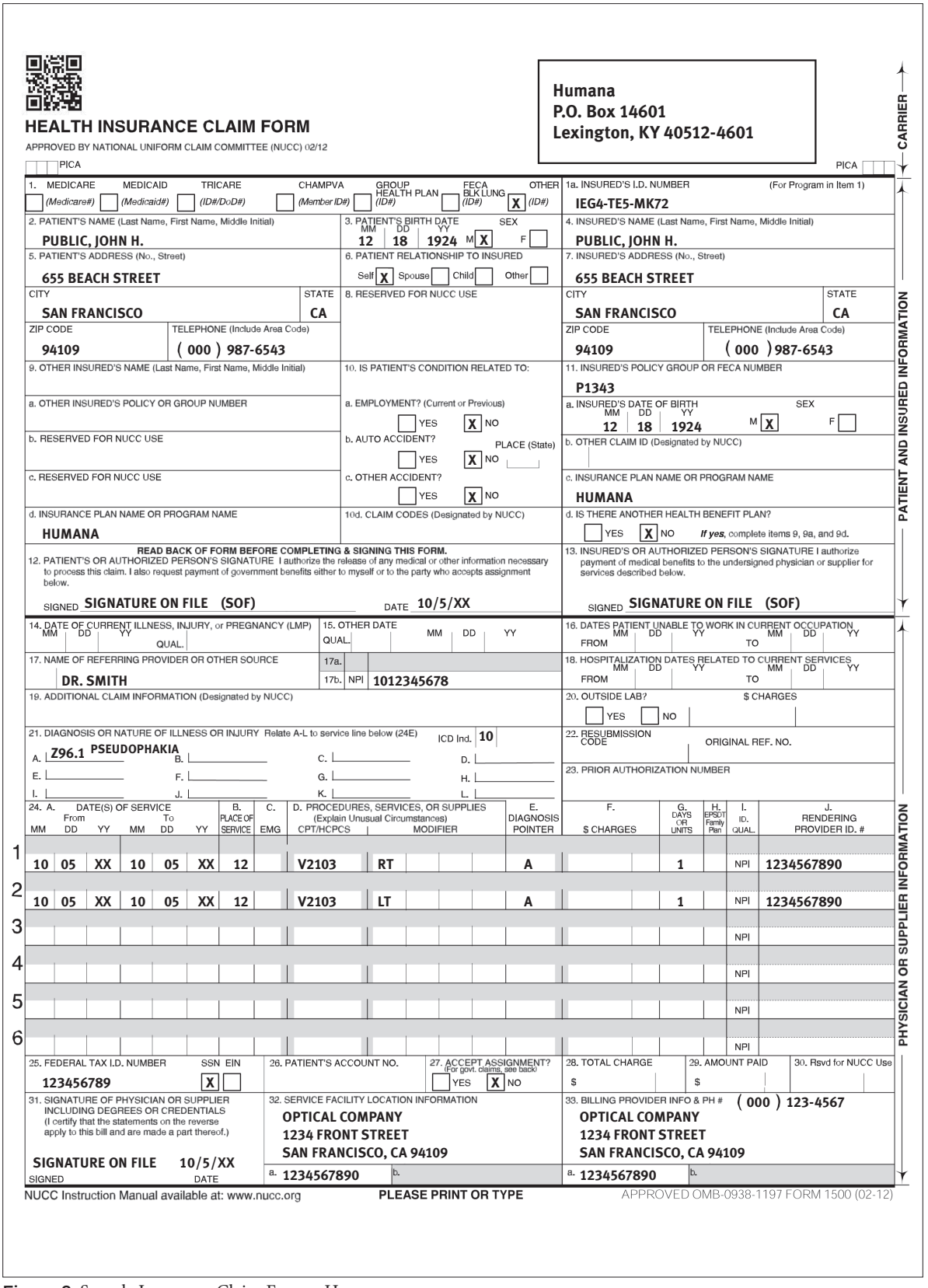
PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: OPTIONAL	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. Rsvd for NUCC Use
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.) SIGNATURE ON FILE 10/5/XX SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: OPTICAL COMPANY, 1234 FRONT STREET, SAN FRANCISCO, CA 94109 a. 1234567890 b.	33. BILLING PROVIDER INFO & PH # (000) 123-4567: OPTICAL COMPANY, 1234 FRONT STREET, SAN FRANCISCO, CA 94109 a. 1234567890 b.	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

***Note: Any item with modifier -EY must be on a separate claim.**

Figure 7 Sample Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Humana
P.O. Box 14601
Lexington, KY 40512-4601

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
IEG4-TE5-MK72	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PUBLIC, JOHN H.	12 18 1924 M [X] F [ ]	PUBLIC, JOHN H.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
655 BEACH STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	655 BEACH STREET
CITY: SAN FRANCISCO / STATE: CA	8. RESERVED FOR NUCC USE	CITY: SAN FRANCISCO / STATE: CA
ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543		ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543
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
		P1343
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 18 1924 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: HUMANA
d. INSURANCE PLAN NAME OR PROGRAM NAME: HUMANA	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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 SIGNATURE ON FILE (SOF) DATE 10/5/XX

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 SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH	17a. / 17b. NPI 1012345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

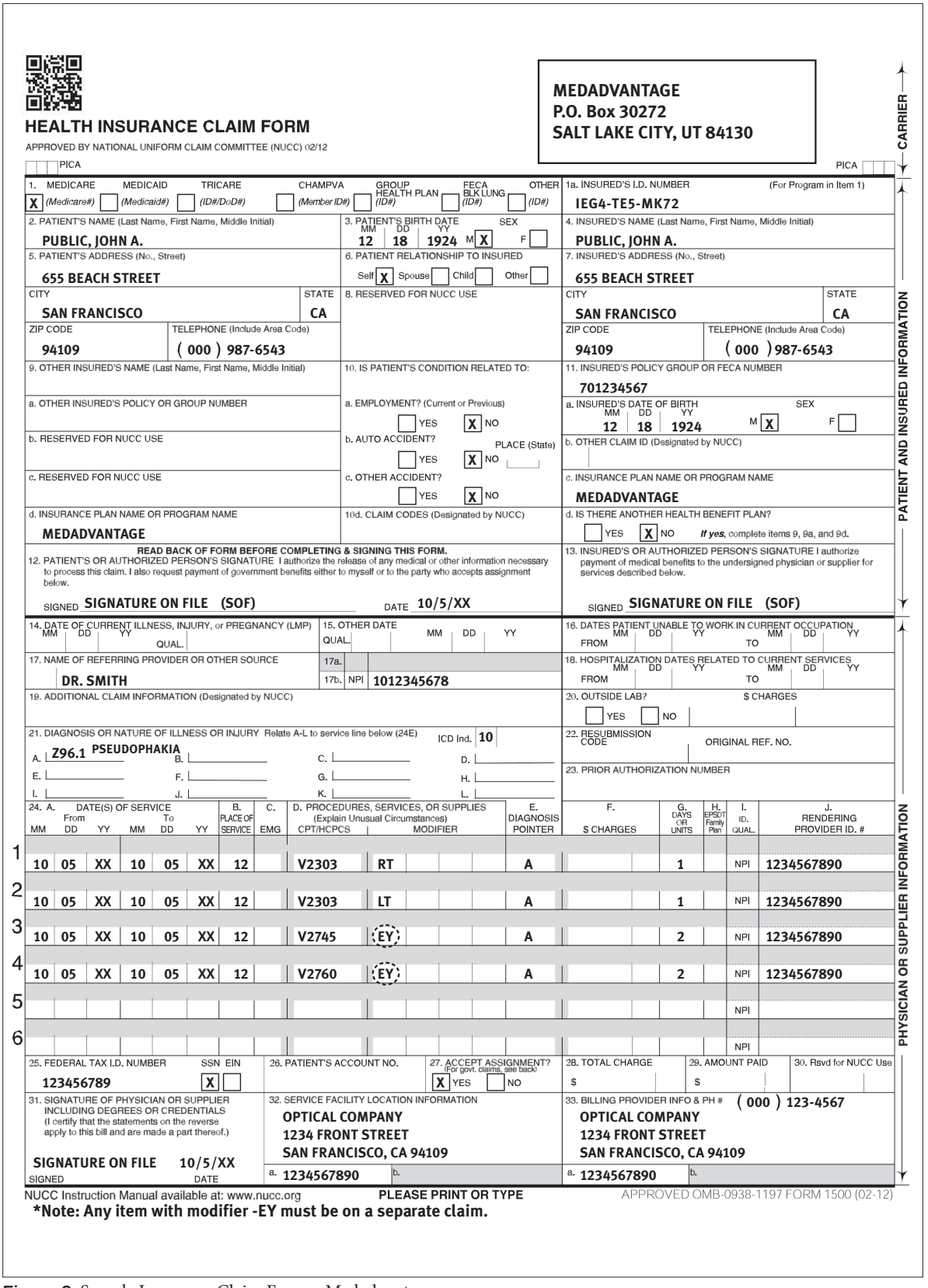
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 05 XX 10 05 XX	12		V2103	RT	A		1		NPI	1234567890
2 10 05 XX 10 05 XX	12		V2103	LT	A		1		NPI	1234567890
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789	[X]	[ ]		YES [ ] NO [X]	$	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (000) 123-4567
SIGNATURE ON FILE 10/5/XX (SIGNED / DATE)	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 8 Sample Insurance Claim Form—Humana



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

MEDADVANTAGE
P.O. Box 30272
SALT LAKE CITY, UT 84130

CARRIER

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN A.

3. PATIENT'S BIRTH DATE: 12 18 1924 | SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN A.

5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET

CITY: SAN FRANCISCO | STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAN FRANCISCO | STATE: CA

ZIP CODE: 94109 | TELEPHONE (Include Area Code): (000) 987-6543

ZIP CODE: 94109 | TELEPHONE (Include Area Code): (000) 987-6543

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: 701234567

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 12 18 1924 | SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDADVANTAGE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDADVANTAGE

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH

17a.

17b. NPI: 1012345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. Z96.1 PSEUDOPHAKIA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	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	10	05	XX	10	05	XX	12		V2303	RT	A		1		NPI	1234567890
2	10	05	XX	10	05	XX	12		V2303	LT	A		1		NPI	1234567890
3	10	05	XX	10	05	XX	12		V2745	EY	A		2		NPI	1234567890
4	10	05	XX	10	05	XX	12		V2760	EY	A		2		NPI	1234567890
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNATURE ON FILE 10/5/XX
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (000) 123-4567
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

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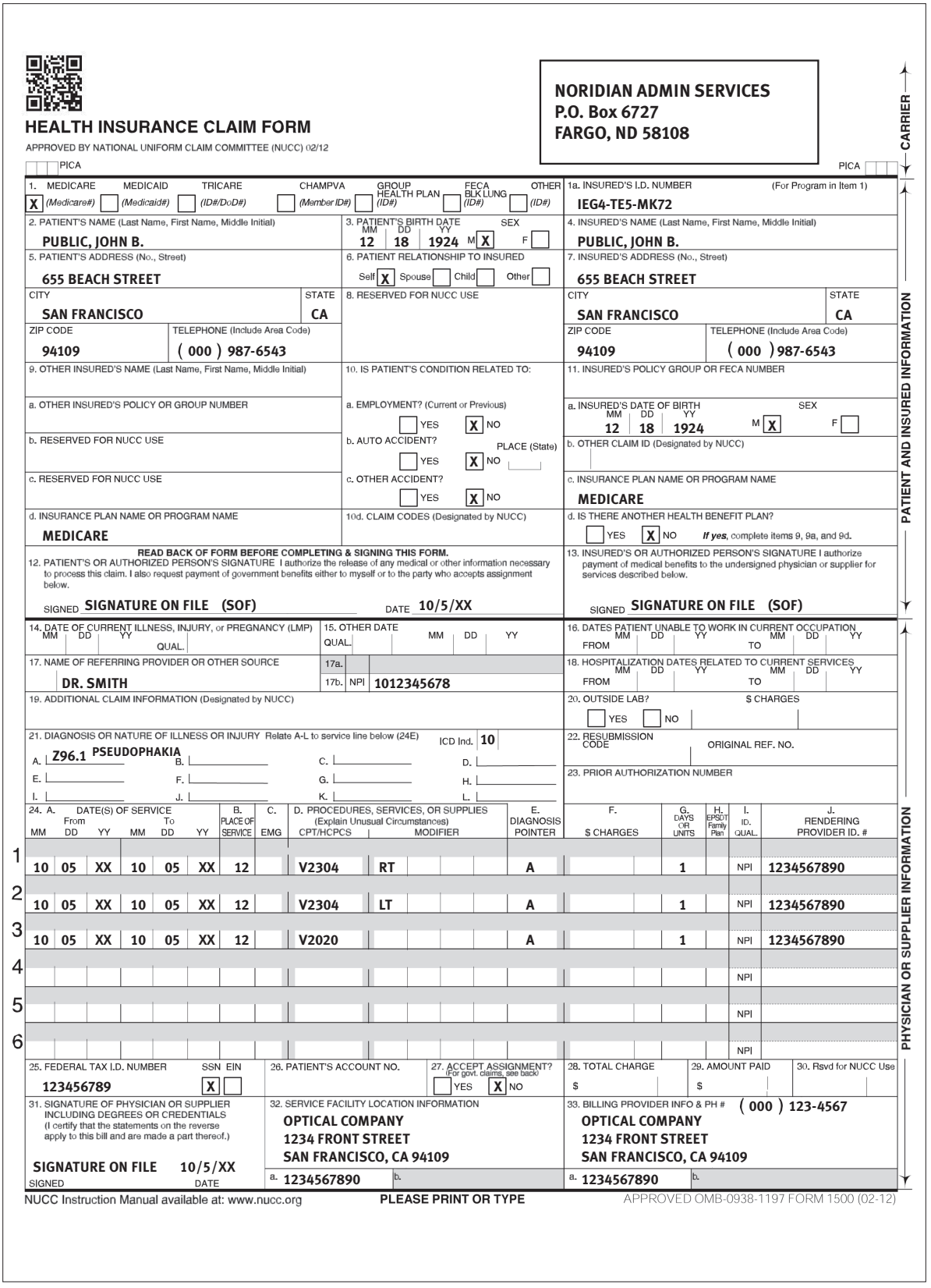
***Note: Any item with modifier -EY must be on a separate claim.**

Figure 9 Sample Insurance Claim Form—Medadvantage



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

NORIDIAN ADMIN SERVICES
P.O. Box 6727
FARGO, ND 58108

CARRIER

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN B.

3. PATIENT'S BIRTH DATE: 12 | 18 | 1924 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN B.

5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET

CITY: SAN FRANCISCO STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAN FRANCISCO STATE: CA

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

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 [X]

a. INSURED'S DATE OF BIRTH: 12 | 18 | 1924 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | YY QUAL.

15. OTHER DATE QUAL. MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH

17a.

17b. NPI 1012345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO MM | DD | YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. Z96.1 PSEUDOPHAKIA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	10 05 XX	10 05 XX	12		V2304	RT		A		1		NPI	1234567890
2	10 05 XX	10 05 XX	12		V2304	LT		A		1		NPI	1234567890
3	10 05 XX	10 05 XX	12		V2020			A		1		NPI	1234567890
4												NPI	
5												NPI	
6												NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

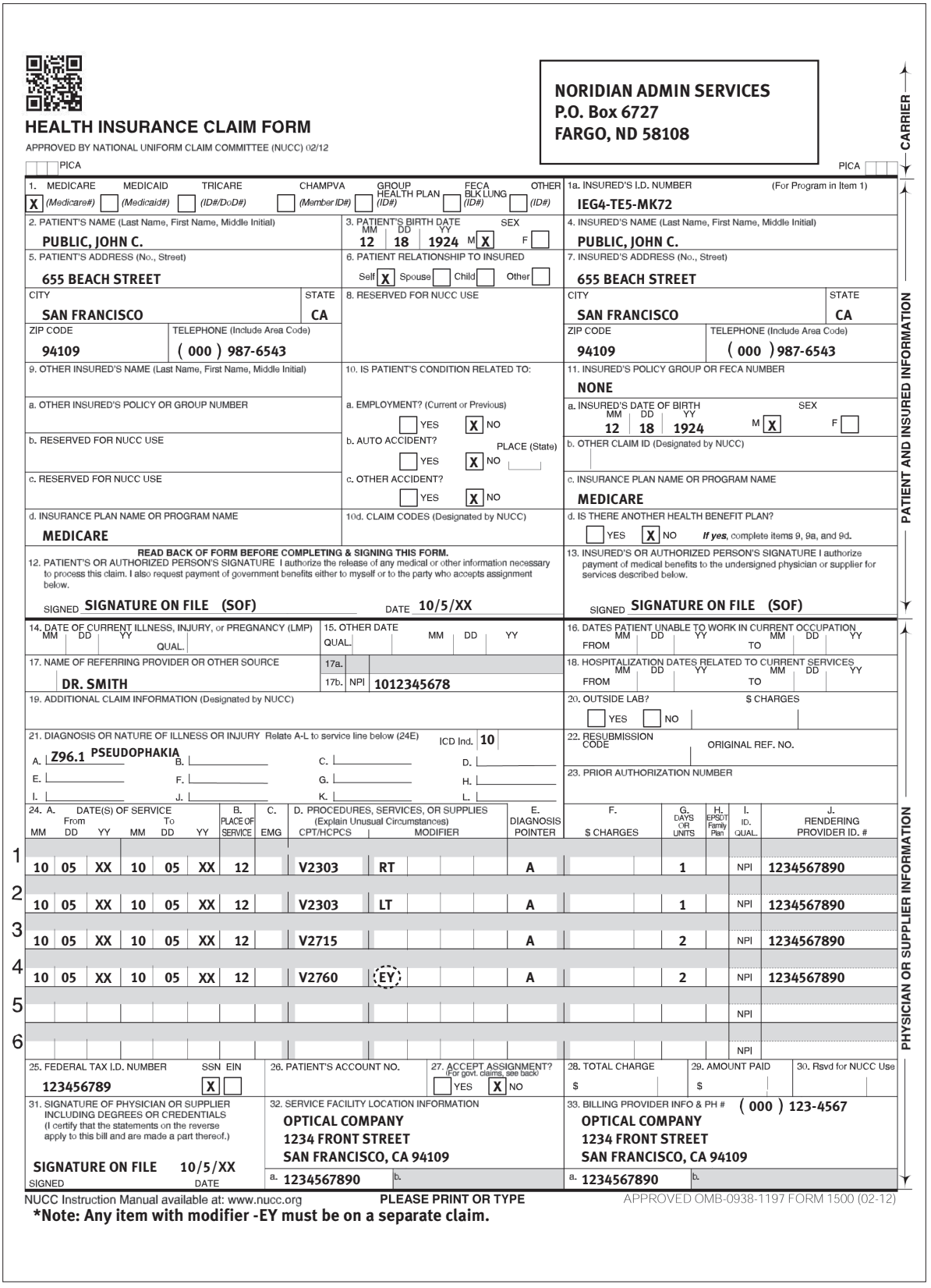
SIGNATURE ON FILE 10/5/XX
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (000) 123-4567
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 10 Sample A Insurance Claim Form—Noridian Admin Services



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

NORIDIAN ADMIN SERVICES
P.O. Box 6727
FARGO, ND 58108

CARRIER

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN C.

3. PATIENT'S BIRTH DATE: 12 18 1924 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN C.

5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET

CITY: SAN FRANCISCO STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAN FRANCISCO STATE: CA

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 12 18 1924 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH

17a.

17b. NPI: 1012345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. Z96.1 PSEUDOPHAKIA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	10	05	XX	10	05	XX	12		V2303	RT	A		1		NPI	1234567890
2	10	05	XX	10	05	XX	12		V2303	LT	A		1		NPI	1234567890
3	10	05	XX	10	05	XX	12		V2715		A		2		NPI	1234567890
4	10	05	XX	10	05	XX	12		V2760	EY	A		2		NPI	1234567890
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNATURE ON FILE 10/5/XX
SIGNED DATE

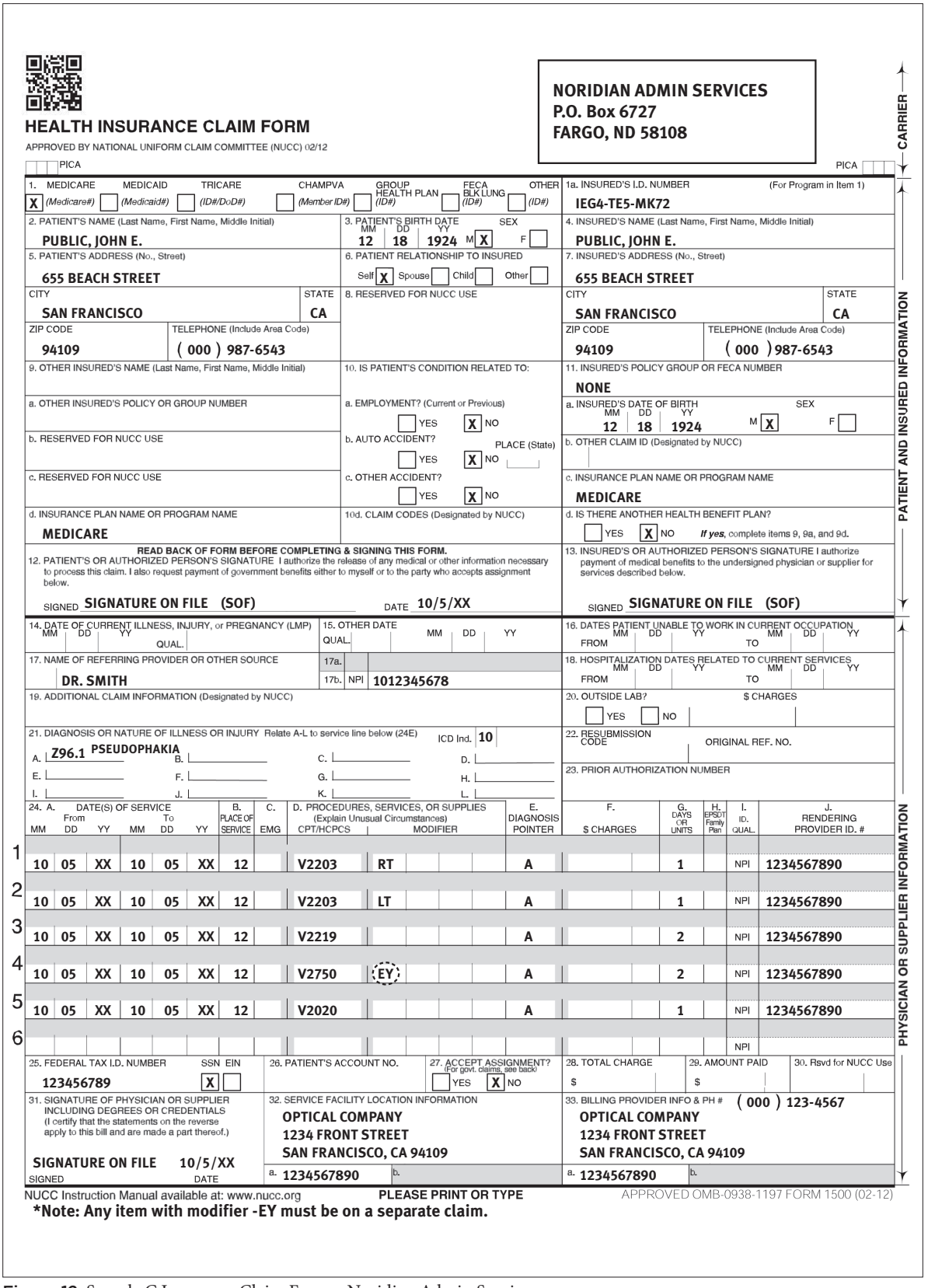
32. SERVICE FACILITY LOCATION INFORMATION
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (000) 123-4567
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

*Note: Any item with modifier -EY must be on a separate claim.

Figure 11 Sample B Insurance Claim Form—Noridian Admin Services



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

NORIDIAN ADMIN SERVICES
P.O. Box 6727
FARGO, ND 58108

CARRIER

PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
[X] (Medicare#)	[ ] (Medicaid#)	[ ] (ID#/DoD#)	[ ] (Member ID#)	[ ] (ID#)	[ ] (ID#)	[ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PUBLIC, JOHN E.	12 18 1924 M [X] F [ ]	PUBLIC, JOHN E.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
655 BEACH STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	655 BEACH STREET
CITY: SAN FRANCISCO / STATE: CA	8. RESERVED FOR NUCC USE	CITY: SAN FRANCISCO / STATE: CA
ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543		ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543
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
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 18 1924 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH	17a. / 17b. NPI 1012345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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 10 05 XX 10 05 XX	12		V2203	RT	A		1		NPI	1234567890
2 10 05 XX 10 05 XX	12		V2203	LT	A		1		NPI	1234567890
3 10 05 XX 10 05 XX	12		V2219		A		2		NPI	1234567890
4 10 05 XX 10 05 XX	12		V2750	EY	A		2		NPI	1234567890
5 10 05 XX 10 05 XX	12		V2020		A		1		NPI	1234567890
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789	[X]	[ ]		[ ] YES [X] NO	$	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (000) 123-4567
SIGNATURE ON FILE 10/5/XX SIGNED DATE	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.

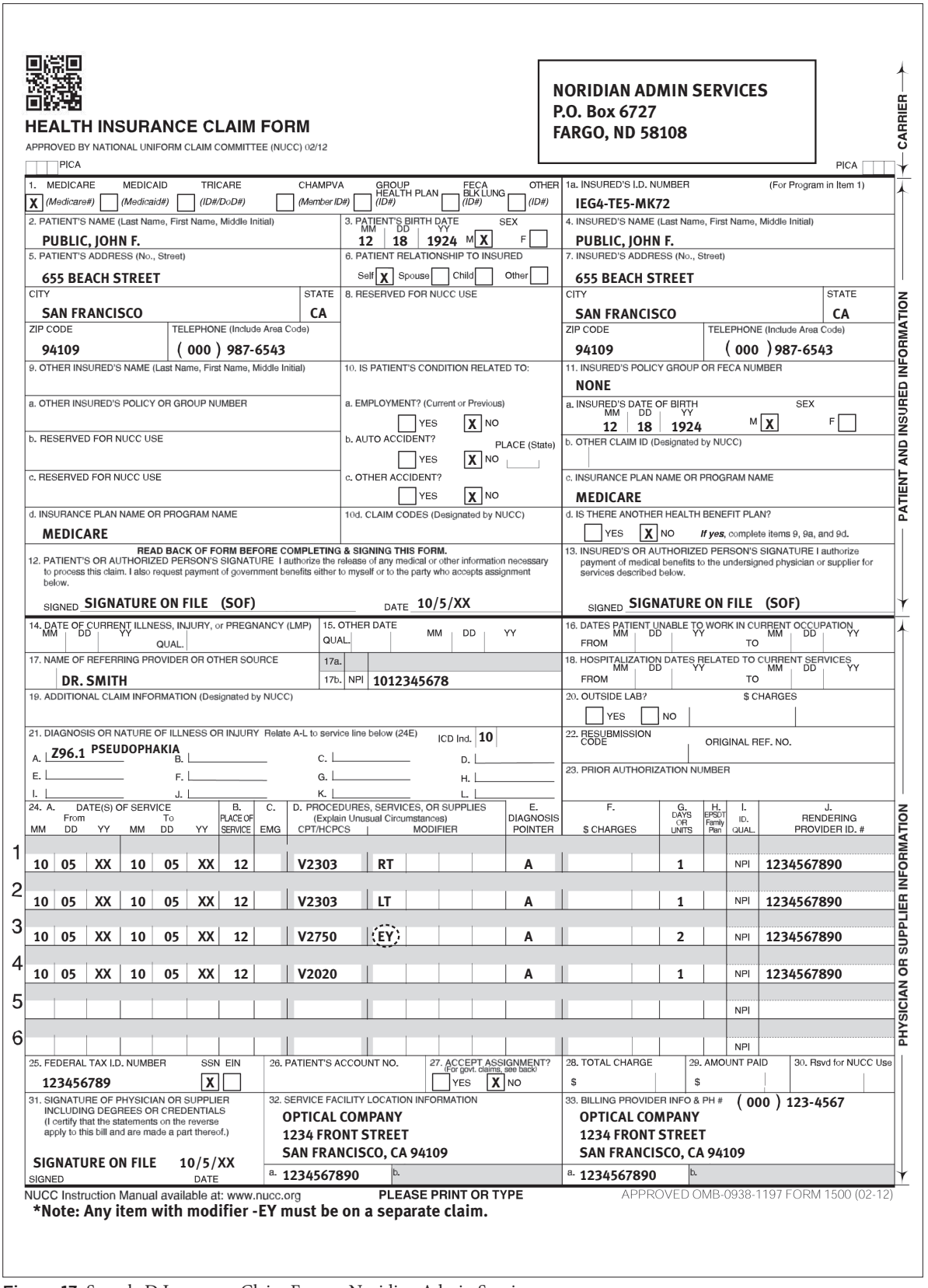
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

***Note: Any item with modifier -EY must be on a separate claim.**

Figure 12 Sample C Insurance Claim Form—Noridian Admin Services



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

NORIDIAN ADMIN SERVICES
P.O. Box 6727
FARGO, ND 58108

CARRIER

PICA

1. MEDICARE [X] (Medicare#)	MEDICAID [ ] (Medicaid#)	TRICARE [ ] (ID#/DoD#)	CHAMPVA [ ] (Member ID#)	GROUP HEALTH PLAN [ ] (ID#)	FECA BLK LUNG [ ] (ID#)	OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PUBLIC, JOHN F.	12 18 1924 M [X] F [ ]	PUBLIC, JOHN F.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
655 BEACH STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	655 BEACH STREET
CITY: SAN FRANCISCO / STATE: CA	8. RESERVED FOR NUCC USE	CITY: SAN FRANCISCO / STATE: CA
ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543		ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543
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
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 18 1924 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE
d. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH	17a. / 17b. NPI 1012345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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 10 05 XX 10 05 XX	12		V2303	RT	A		1		NPI	1234567890
2 10 05 XX 10 05 XX	12		V2303	LT	A		1		NPI	1234567890
3 10 05 XX 10 05 XX	12		V2750	EY	A		2		NPI	1234567890
4 10 05 XX 10 05 XX	12		V2020		A		1		NPI	1234567890
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789	[X]	[ ]		[ ] YES [X] NO	$	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (000) 123-4567
SIGNATURE ON FILE 10/5/XX SIGNED DATE	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.

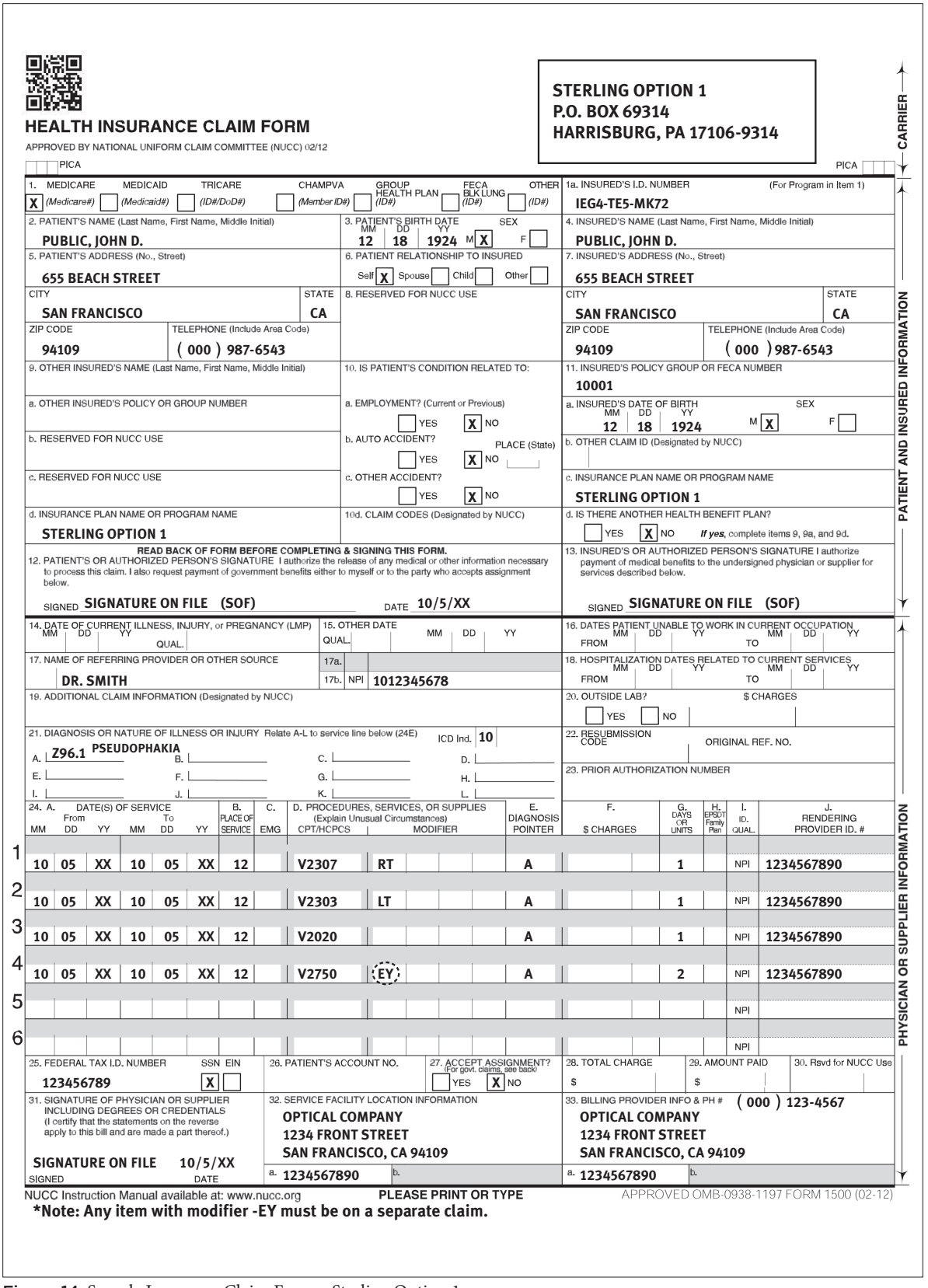
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

***Note: Any item with modifier -EY must be on a separate claim.**

Figure 13 Sample D Insurance Claim Form—Noridian Admin Services



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

STERLING OPTION 1
P.O. BOX 69314
HARRISBURG, PA 17106-9314

CARRIER

PICA

1. MEDICARE [X] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN D.

3. PATIENT'S BIRTH DATE: 12 18 1924 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN D.

5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET

CITY: SAN FRANCISCO STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAN FRANCISCO STATE: CA

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

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: 10001

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 12 18 1924 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STERLING OPTION 1

d. INSURANCE PLAN NAME OR PROGRAM NAME: STERLING OPTION 1

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH

17a.

17b. NPI 1012345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	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	10	05	XX	10	05	XX	12		V2307	RT	A		1		NPI	1234567890
2	10	05	XX	10	05	XX	12		V2303	LT	A		1		NPI	1234567890
3	10	05	XX	10	05	XX	12		V2020		A		1		NPI	1234567890
4	10	05	XX	10	05	XX	12		V2750	EY	A		2		NPI	1234567890
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNATURE ON FILE 10/5/XX
SIGNED DATE

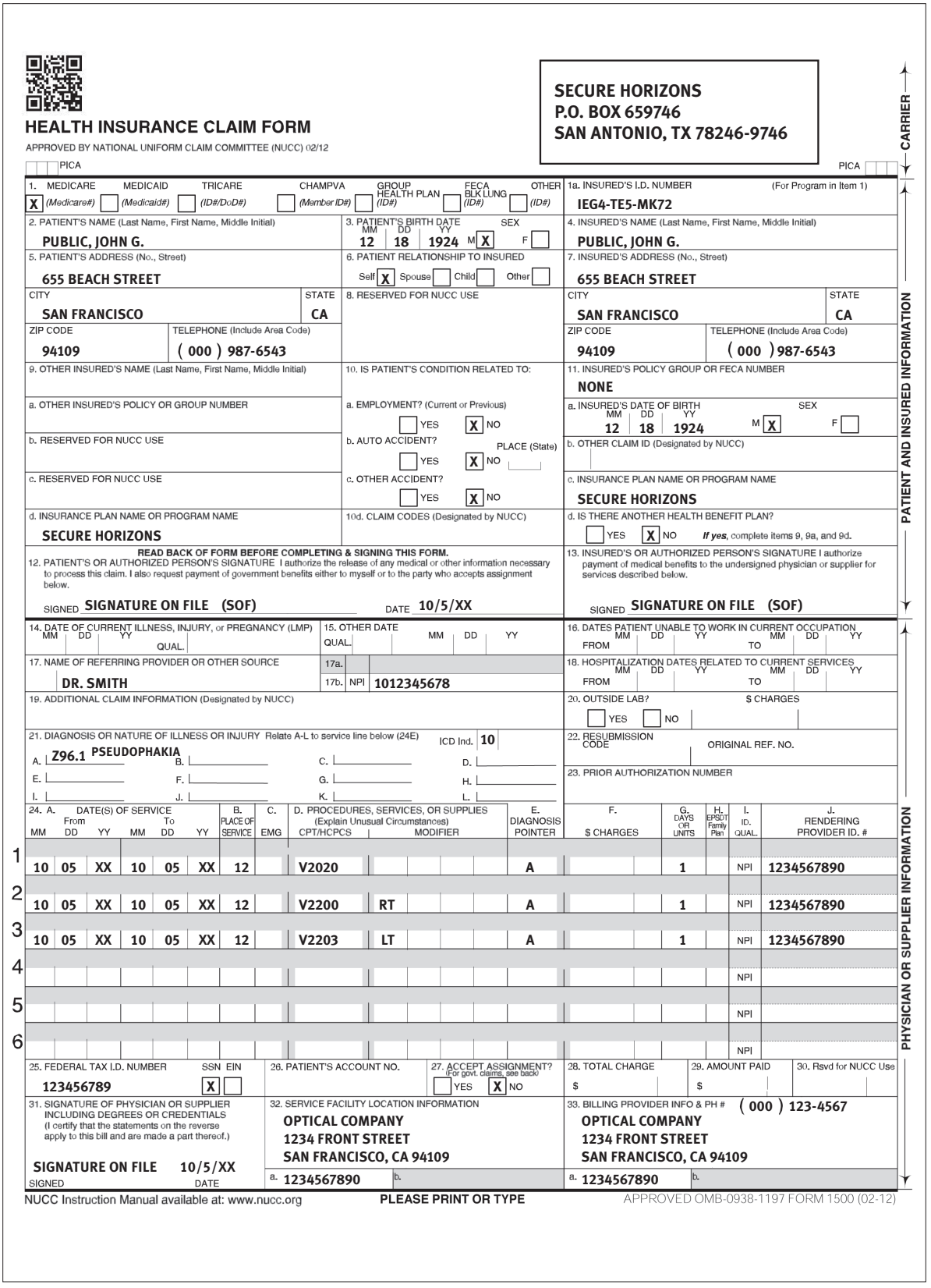
32. SERVICE FACILITY LOCATION INFORMATION
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (000) 123-4567
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

*Note: Any item with modifier -EY must be on a separate claim.

Figure 14 Sample Insurance Claim Form—Sterling Option 1



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

SECURE HORIZONS
P.O. BOX 659746
SAN ANTONIO, TX 78246-9746

CARRIER

PICA

1. MEDICARE [X] (Medicare#)	MEDICAID [ ] (Medicaid#)	TRICARE [ ] (ID#/DoD#)	CHAMPVA [ ] (Member ID#)	GROUP HEALTH PLAN [ ] (ID#)	FECA BLK LUNG [ ] (ID#)	OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
IEG4-TE5-MK72	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PUBLIC, JOHN G.	12 18 1924 M [X] F [ ]	PUBLIC, JOHN G.
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
655 BEACH STREET	Self [X] Spouse [ ] Child [ ] Other [ ]	655 BEACH STREET
CITY: SAN FRANCISCO / STATE: CA	8. RESERVED FOR NUCC USE	CITY: SAN FRANCISCO / STATE: CA
ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543		ZIP CODE: 94109 / TELEPHONE (Include Area Code): (000) 987-6543
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
		NONE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 12 18 1924 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: SECURE HORIZONS
d. INSURANCE PLAN NAME OR PROGRAM NAME: SECURE HORIZONS	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH	17a. / 17b. NPI 1012345678	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10 A. Z96.1 PSEUDOPHAKIA B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

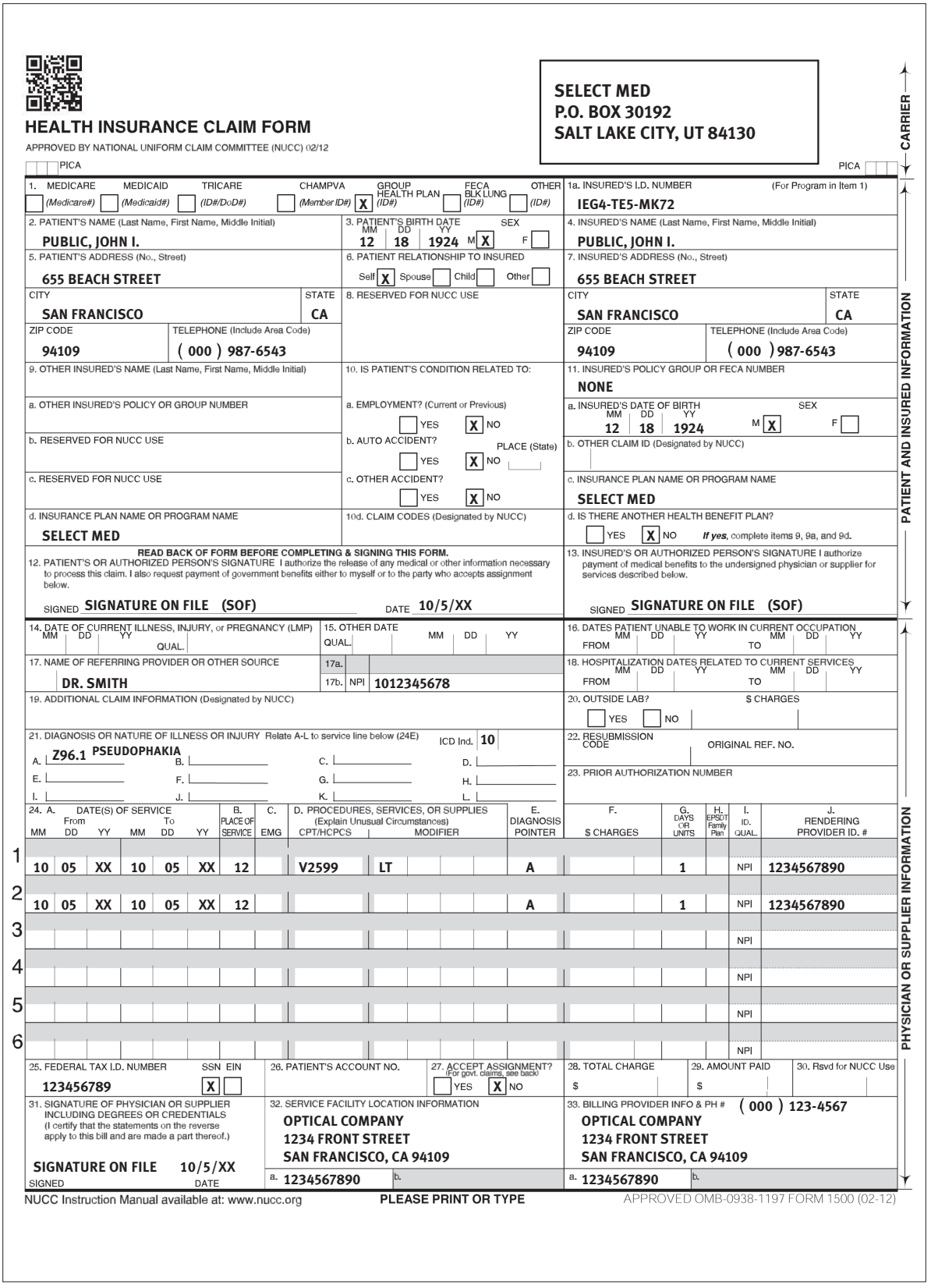
	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 05 XX 10 05 XX	12		V2020		A		1		NPI	1234567890
2	10 05 XX 10 05 XX	12		V2200	RT	A		1		NPI	1234567890
3	10 05 XX 10 05 XX	12		V2203	LT	A		1		NPI	1234567890
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789 [X]		[ ] YES [X] NO	$	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (000) 123-4567
SIGNATURE ON FILE 10/5/XX SIGNED DATE	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.	OPTICAL COMPANY 1234 FRONT STREET SAN FRANCISCO, CA 94109 a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 15 Sample Insurance Claim Form—Secure Horizons



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

SELECT MED
P.O. BOX 30192
SALT LAKE CITY, UT 84130

CARRIER

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN [X] (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): IEG4-TE5-MK72

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN I.

3. PATIENT'S BIRTH DATE: 12 18 1924 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PUBLIC, JOHN I.

5. PATIENT'S ADDRESS (No., Street): 655 BEACH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 655 BEACH STREET

CITY: SAN FRANCISCO STATE: CA

8. RESERVED FOR NUCC USE

CITY: SAN FRANCISCO STATE: CA

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

ZIP CODE: 94109 TELEPHONE (Include Area Code): (000) 987-6543

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: NONE

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 12 18 1924 SEX: M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: SELECT MED

d. INSURANCE PLAN NAME OR PROGRAM NAME: SELECT MED

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

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: SIGNATURE ON FILE (SOF) DATE: 10/5/XX

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: SIGNATURE ON FILE (SOF)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. SMITH

17a.

17b. NPI: 1012345678

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. Z96.1 PSEUDOPHAKIA B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	10	05	XX	10	05	XX	12		V2599	LT	A		1		NPI	1234567890
2	10	05	XX	10	05	XX	12				A		1		NPI	1234567890
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [X]

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNATURE ON FILE 10/5/XX
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

33. BILLING PROVIDER INFO & PH # (000) 123-4567
OPTICAL COMPANY
1234 FRONT STREET
SAN FRANCISCO, CA 94109
a. 1234567890 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 16 Sample Insurance Claim Form—Select Med

ASK THE CODING EXPERTS

The Academy's coding experts provide weekly up-to-date answers to frequently asked questions. These carefully researched responses cover federal and commercial payers and provide valuable tips on how to improve documentation, submit clean claims and appropriately maximize reimbursement. Visit Coding News and Expert Advice at aao.org/coding to view the most recent FAQs and submit your questions.

Q. Who is responsible for payment of a Fresnel prism?

A. It depends upon the payer. Payment is typically the patient's responsibility.

Q. If a beneficiary still needs post-cataract eyewear following the insertion of a Presbyopia-correction IOL, will Medicare cover the expenses?

A. Yes, Section 1861(s)(8) permits payment of one pair of eyeglasses or contact lenses following cataract surgery with an insertion of any type of intraocular lens.

Q. When are glasses a covered benefit?

A. Medicare will cover one pair of glasses after each cataract is removed.

The covered diagnoses are limited to:

- Z96.1 Pseudophakia
- H27.01–27.03 Aphakia
- Q12.3 Congenital aphakia

If the patient has a diagnosis other than these, the claim may be denied.

Replacement glasses and lenses are noncovered.

Q. How do we code for aphakic contact lens fitting?

A. CPT code 92311 Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye.

CPT code 92312 Corneal lens for aphakia, both eyes.

Remember that the supply of contact lenses may be reported as part of the service—or it may be reported separately by using the appropriate supply codes such as V2520–V2523.

MEETING A SAFE HARBOR UNDER THE ANTI-KICKBACK STATUTE

Taken from "Stark Bans on Self-Referrals" Claire H. Topp, Esq., and Dorsey & Whitney LLP (2001 Dorsey and Whitney LLP)

The following arrangements meet a safe harbor under the Anti-Kickback Statute:

Employees

An ophthalmologist may compensate their employees, including ophthalmologists, optometrists, and opticians, for referrals to items sold by the optical shop. The safe harbor protects any amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the furnishing of any item or service for which payment may be made, in whole or in part, under a governmental health program. The regulators noted in the comments to the safe harbor that the safe harbor permits an employer to pay an employee in whatever manner they choose for having that employee assist in the solicitation of program business.

Independent Contractors/Management Agreements

An ophthalmologist may not compensate an ophthalmologist, optometrist, or an optician who is an independent contractor based on referrals to items sold by the optical shop that are reimbursable by a governmental health program. To meet the safe harbor for professional service arrangements, the agreement with the independent contractor would have to meet all of the following seven standards applicable to personal service arrangements:

1. The arrangement is embodied in a written agreement signed by the parties.
2. The term of the agreement is for not less than one year.
3. The agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.
4. If the agreement is intended to provide for the services of the agent on a periodic, sporadic, or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of the intervals, their precise length, and the exact charge for the intervals.
5. The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purposes of the services.
6. The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under the Medicare/Medicaid program.

7. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any federal or state law.

Similarly, if an ophthalmologist entered into a management agreement for the management of the optical shop, the management agreement would have to meet the seven requirements described above. Most notably, the regulators have indicated that a percentage of net revenues compensation provision does not qualify for this safe harbor because the compensation would not be an aggregate amount, fixed in advance, as the safe harbor requires.

Optical Shop Owned by a Solo Practitioner

An ophthalmologist may receive a dividend payment of profit from his or her ownership of a solo practice that operates an optical shop, if the following two standards are met:

1. The equity interests in the practice are held by licensed health care professionals who practice in the practice or group.
2. The equity interests are in the practice or group itself, and not some subdivision of the practice or group.

Optical Shop Operated as Part of Group Practice

An ophthalmologist may receive a dividend payment from his or her ownership of a group practice that operates an optical shop, if, in addition to the two requirements discussed above for solo practitioners, the practice:

1. Meets the definition of "group practice" in Stark II; and
2. Is a unified business with centralized decision-making, pooling of expenses and revenues, and a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.

Thus, although Phase I of the Stark II regulations excludes conventional eyeglasses and contact lenses provided to Medicare patients furnished after cataract surgery from the prohibitions of Stark II, an ophthalmologist owner of a group practice from which he or she will receive a dividend payment does not qualify for the exception unless his optical shop is owned by an entity that qualifies as a "group practice" under Stark II.

Specifically, Phase I of the Stark II regulations defines a "group practice" based on nine characteristics that are briefly described below:

1. Single legal entity. The group practice must be a single legal entity formed primarily for the purpose of being a physician group practice in any organizational form recognized by the state in which the group practice achieves its legal status. The single legal entity may not be organized or owned (in whole or in part) by another medical practice that is an operating physician practice regardless of whether the medical practice meets the conditions for a group practice.
2. Physicians. The group practice must have at least two ophthalmologists who are members of the group (whether employees or direct or indirect owners).
3. Range of care. Each ophthalmologist who is a member of the group (which includes independent contractors) must furnish substantially the full range of patient care services that the ophthalmologist routinely furnishes, including medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, and personnel.
4. Services furnished by group practice members. Substantially all of the patient care services of the ophthalmologists who are members of the group (that is, at least 75 percent of the total patient care services of the group practice members) must be furnished through the group and billed under a billing number assigned to the group, and the amounts received must be treated as receipts of the group.
5. Distribution of expenses and income. The overhead expenses of, and income from, the practice must be distributed according to methods that are determined before the receipt of payment for the services giving rise to the overhead expenses or producing the income.
6. Unified business. The group practice must be a unified business having at least the following features: (a) centralized decision-making by a body representative of the group practice that maintains effective control over the group's assets and liabilities (including, but not limited to, budgets, compensation, and salaries); (b) consolidated billing, accounting, and financial reporting; and (c) centralized utilization review. Although Phase I of the regulations expressly indicates that location and specialty-based compensation practices are permitted with respect to revenues derived from services that are not designated health services and may be permitted with respect to revenues that are designated health services in limited circumstances, the Anti-Kickback Statute safe harbor requires that there is a compensation/profit distribution system that is not based on satellite offices operating substantially as if they were separate enterprises or profit centers.

7. Volume or value of referrals. No ophthalmologist who is a member of the group practice directly or indirectly receives compensation based on the volume or value of referrals by the ophthalmologist, except as provided under the special rule for productivity bonuses and profit shares (discussed in 9. below).
8. Physician–patient encounters. Members of the group must personally conduct no less than 75 percent of the ophthalmologist–patient encounters of the group practice.
9. Special rule for productivity bonuses and profit shares. An ophthalmologist in a group practice may be paid a share of "overall profits" of the group or a productivity bonus based on services that he or she has personally performed, provided that the share or bonus is not determined in any manner that is directly related to the volume or value of referrals of designated health services by the ophthalmologist. A share of the "overall profits" means the group's entire profits derived from designated health services payable by Medicare or Medicaid or the profits derived from designated health services payable by Medicare or Medicaid of any component of the group practice that consists of at least five ophthalmologists. Compensation is not directly related to the volume or value of referrals of designated health services by the ophthalmologist if the revenues derived from designated health services constitute less than 5 percent of the group practice's total revenues, and the allocated portion of those revenues to each ophthalmologist in the group practice constitutes 5 percent or less of his or her total compensation from the group.

Ophthalmologist/Group Practice Ownership of Separately Incorporated Optical Shops

The safe harbor discussed above, which protects an ophthalmologist's ownership of a group practice, including an optical shop operated as part of the group practice, expressly does not protect investments made by members of a group practice jointly in separately incorporated optical shops or other separate entities. Furthermore, an ophthalmologist's or group practice's ownership of a separately incorporated optical shop does not meet any safe harbor. Although a failure to meet a safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback Statute, such failure does raise uncertainty as to whether the arrangement does not violate the Anti-Kickback Statute and thus whether the arrangement is excluded from Stark II.

It is worth noting that where an ophthalmologist does not expressly refer the patient to the optical shop from which the patient ultimately receives Medicare- or Medicaid-covered eyeglasses or contact lenses but signs the prescription for the eyeglasses or contact lenses, the Phase I regulations indicate that the regulators will presume that the patient received their eyeglasses or contact lenses as a result of the ophthalmologist's referral to that optical shop. Although the regulators will permit an ophthalmologist to rebut that presumption by establishing that they mentioned no specific optical shop or that the patient was directly referred by some other independent individual or through an unrelated entity, it may be difficult to rebut the presumption if the optical shop where the patient had their prescription filled is located near the ophthalmologist's office. In addition, state law may require that the ophthalmologist disclose their ownership in the optical shop.

In summary, the new exception created by Phase I of the Stark II final regulations to exclude one pair of conventional eyeglasses and contact lenses furnished after cataract surgery gives ophthalmologists more flexibility regarding the operation of their optical shop; however, group practices owned by for-profit corporations will still need to comply with the definition of "group practice" found in the Stark II regulations described above if they want certainty that they fall within the Stark II exception.

In addition to "prosthetics, orthotics, and prosthetic devices," Stark II applies to ten other designated health services including inpatient or outpatient hospital services, clinical laboratory services, and radiology and certain other imaging services. Phase I of the Stark II final regulations clarifies that the term "designated health services" does not include services that are reimbursed by Medicare as part of a composite rate, for example, ambulatory surgical center services. Further, although Stark II applies to IOLs implanted in a hospital, Phase I clarified that Stark II does not apply to intraocular lenses implanted in an ambulatory surgical center on the grounds that the payment for IOLs is fixed when implanted in an ambulatory surgical center because it is covered under the fixed ambulatory surgical center payment rate. The exception is for IOLs furnished by the referring ophthalmologist or a member of the referring ophthalmologist's group practice in a Medicare-certified ASC with which the referring ophthalmologist has a financial relationship provided that (1) the IOL is implanted in the patient during a surgical procedure performed in the same ASC where the IOL is furnished; (2) the arrangement for the furnishing of the IOL does not violate the Anti-Kickback Statute; and (3) billing and claims submission for the IOLs complies with all federal and state laws and regulations.

VALIDITY OF ORDERS

Optical suppliers must maintain documentation that proves authenticity and validity of orders, as well as claims for seven years. Medicare may review orders for validity during an onsite inspection and will accept the following forms of proof:

- An original documents (handwritten in ink)
- A photo copy
- A faxed image
- Electronically maintained document

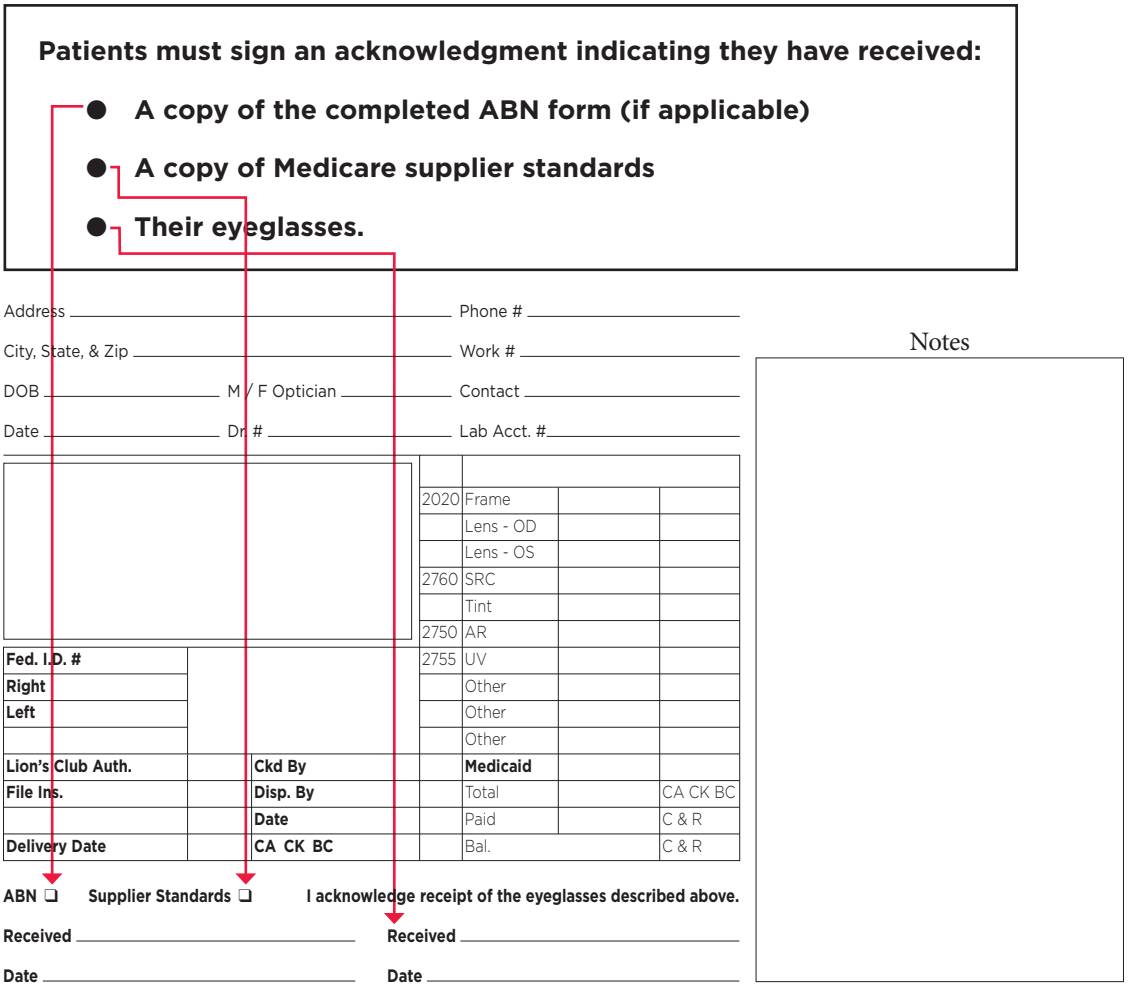


Figure 17 Validity of Orders