

# AcrySof® ReSTOR® Sample Claim Form

Use for billing in ASC setting

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY		5. INSURED'S DATE OF BIRTH MM DD YY	
6. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)			
1. <b>366 .xx</b> ←			
2. <b>367.4</b>			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAY'S OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 01 27 07 - 01 27 07 22		66984	
2 V2788 GY		1 XXX .XX	
3		2 XX .XX	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL IDENTIFICATION NUMBER		29. AMOUNT PAID	
31. SIGNATURE AND TITLE OF BILLING PROVIDER		30. BALANCE DUE	

**IMPORTANT NOTE:** It is important that the diagnosis for the cataract procedure point to the cataract diagnosis. The non-covered presbyopia component should point to the presbyopia diagnosis.

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

**V2788 (Presbyopia correcting function of an IOL)**

**Use modifier GY - Item or service statutorily excluded.**

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

**The items listed on this claim form are not intended to be comprehensive of all services and supplies provided.**