

AcrySof® ReSTOR®
Sample Claim Form
Use for billing physician services

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"/> CHAMPUS <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) Doe, John		3. PATIENT'S BIRTH DATE MM DD YY M F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		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"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
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)		22. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
1. 366 . xx		2. 367.4	
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. 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	
3. 1		XXX .XX	
4. 2		XX .XX	
5. 1		XXX .XX	
6. 2		XX .XX	
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 #			

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.

366 . xx
367.4

V2788 (Presbyopia correcting function of an IOL)

Use modifier GY - Item or service statutorily excluded.

Customary charges for non-covered services equals patient payment.

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.