

1	2	3a PAT. CNTRL #	b. MED. REC. #	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH														
8 PATIENT NAME a Doe, John		9 PATIENT ADDRESS a		b	c	d	e													
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
31 OCCURRENCE DATE	32	33 OCCURRENCE DATE	34	35 OCCURRENCE FROM	36 THROUGH	37	38	39 VALUE CODES	40	41 VALUE CODES	42									
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48	49	50	51	52	53									
1	0363 Surgery	66984	05-05-07	1	X,XXX XX															
2	025X Pharmacy		05-05-07	1	XXX XX															
3	0276 IOL	V2632	05-05-07	1	1 00															
4	037X Anesthesia	00142	05-05-07	1	XXX XX															
5	027X Supplies		05-05-07	1	XXX XX															
6	0276 ReSTOR Lens	V2788	05-05-07	1	XXX XX															
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50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID	58 INSURED'S NAME	59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.								
63 TREATMENT AUTHORIZATION CODES	64	65 EMPLOYER NAME	66 DX	67	68	69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73										
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS	81CC a	81CC b	81CC c	81CC d										

List charge for cataract surgery (which includes STANDARD monofocal IOL).

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

Claim should include presbyopia diagnosis.

366.xx 367.4

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