Medicare Guidelines and Updates

With Mario Fucinari DC, CCSP®, APMP, MCS-P, CPCO
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Presented by NCMIC

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About Dr. Mario Fucinari, DC, APMP, CPCO, MCS-P

- Graduate of Palmer College of Chiropractic - 1986
- Currently in Full Time Practice in Decatur, Illinois
- Certified Chiropractic Sports Physician (CCSP) – Logan College of Chiropractic
- Certified Medical Compliance Specialist Physician – (MCS-P)
- Certified Professional Compliance Officer – CPCO (AAPC)
- Diplomate Academy of Integrative Pain Management (APMP)
- Post-graduate Faculty of Palmer College of Chiropractic, NYCC, D'Youville College, Life West and Western States Chiropractic College
- National Speaker's Bureau for NCMIC, ChiroHealthUSA and Foot Levelers and many state associations
- Member Medicare Carrier Advisory Committee
- Past President of Illinois Chiropractic Society (ICS)
- Chairman, ICS Medicare Committee
- ICS Chiropractor of the Year 2012
- Member of ACA and ICS

Keep up with updates as they occur! For the latest in compliance, coding and Medicare go to www.facebook.com/askmario and "Like" us
Put us in your notifications.

Chiropractic has consistently ranked number one for errors. The reasons for our errors are ranked as follows:
Insufficient documentation (Number One!)
Medically unnecessary services (maintenance care)
Incorrect coding

Risk Analysis
Required Compliance Documents You MUST Have in Your Office

- Corporate Compliance Manual
  - Policies and Procedures
  - Non-Retaliation Policy
  - Non-Harassment Policy
  - Staff Training Required
- HIPAA Manual
  - Privacy Policy
  - Business Associate Agreement
  - Staff Training Required

It has become quite clear that the adoption of the "Seven Elements of a Compliance Program" have become a mainstay of compliance in the corporate world and in healthcare. To protect oneself by showing a culture of ethics, it is recommended that these elements are adopted to demonstrate

the ethical culture of the organization.

Seven Elements of Your Compliance Program

1. Implement written policies and procedures;
   a. Standards of Conduct (Code of Conduct)
2. Designate a compliance officer;
   a. Designate an officer who will oversee the compliance program
   b. The officer can be the doctor, office manager or outside entity
3. Conduct comprehensive training and education;
   a. Schedule and implement training of personnel
4. Develop accessible lines of communication;
   a. Must have a complaint process such as hotlines or other mechanisms for reporting of alleged non-compliant behavior.
   b. The complaint process should provide anonymity and protection from retaliation
5. Conduct auditing and internal monitoring;
   a. Auditing
      - Implement risk evaluation and auditing techniques
      - Best if done by an outside entity so as not to be biased
      - Must be independent and objective
   b. Monitoring
      - Based on assessment of risk
      - Used as a management tool
      - Day-to-day activities within the office
      - Scalable to the risks and resources

6. Enforcing standards through well publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective actions.

The Eighth Element added is that all employees must be checked against the OIG Exclusion Database http://exclusions.oig.hhs.gov/ This is recommended to be done quarterly.

Policies
"The set of basic principles and associated guidelines, formulated and enforced by the governing body of an organization, to direct and limit its actions in pursuit of long-term goals."*

Procedures
"A fixed step-by-step sequence of activities or course of action…that must be followed in the same order to correctly perform a task."

All the work is done for you! Just answer the questions, complete the forms and you are on your way! Manual available at www.askmario.com

MEDICARE PROCEDURES

Parts of Medicare Plan Coverage

Part A – Hospital stays, skilled nursing facility care, hospice care, home health care and blood services.
Part B – Chiropractic care, outpatient hospital services, physical therapy, etc.
Part C – HMO plan. Cannot have part B and Part C
Part D – Since 2006. Prescription Drug plans

Medicare Advantage (Part C) Benefit Questions:

1. Do you follow the Medicare fee schedule?
2. Do you cover services other than manipulation?
3. Do you accept the AT modifier?
4. Do you accept/honor the ABN form?

MEDIGAP PLANS
Part F

- Both Part A and Part B deductibles are covered by the plan
- Best if you've got serious or chronic health conditions and have a lot of medical expenses each year.
- Being phased out to new beneficiaries in 2020

Part G

- Same coverage as Plan F except for the Part B deductible, which is $185
- Part F and G are the only Medicare Supplement Plans that offer coverage for Part B excess charges
- There are no plans to phase out Plan G in 2020

Part N

- No coverage for Part B deductible
- No coverage for Part B excess charges
- You may have a copay of up to $20 for doctor visits and $50 for hospital visits that don't result in admission.
- There are no plans to phase out Plan G in 2020

Railroad Medicare

Medicare benefits for eligible railroad retirees.

Palmetto Government Benefit Administrators (Palmetto GBA)
Railroad Medicare Part B
P.O. Box 10066
Augusta, Georgia 30999-0001
1-800-833-4455

*Not eligible for traditional Medicare carrier coverage

Front Desk Procedures

Revalidation Required with Medicare The Medicare Card

CMS has released images of the newly designed and renamed Medicare Beneficiary Identifier (MBI) card. The Medicare Beneficiary Identifier card will contain a unique, randomly-assigned 11-character identification number that replaces the current Social Security- based number. Each MBI identifier will be randomly generated. An example of the new identifier would be: 1EG4-TE5-MK73

YOU CAN NOT OPT OUT OF MEDICARE! (Jan 2004)

MedLearn Matters SE0479

"Opting out of Medicare is not an option for Doctors of Chiropractic. Note that opting out and being non-participating are not the same things. Chiropractors may decide to be participating or non-participating with regard to Medicare, but they may not opt out."

If you see a Medicare patient, you must file a claim for them or have the authority to file a claim if the patient requests you to do so.

Medicare Processing Manual §70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims (Rev. 170, 05-07-04)

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis. For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished…

Medicare Part B

- **In 2019 the deductible will be $185**
- Only covered services are applied to the deductible
- Co-insurance: 20 percent.
- **It is illegal to waive ANY part of the deductible or coinsurance**

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements?

People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. (Released by CMS January 17, 2019)

Offering Gifts and Other Inducements to Beneficiaries
(OIG Advisory Opinion 2002)
A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of **up to $10,000 for each wrongful act.** The statute defines "remuneration" to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.

The OIG has interpreted the prohibition to permit providers to offer beneficiaries inexpensive gifts (other than cash or cash equivalents) or services without violating the statute. For enforcement purposes, inexpensive gifts or services are those that have a retail value of not more than $10 individually, and no more than $50 in the aggregate annually per patient.
Similarly, there is no meaningful statutory basis for a broad exemption based on the financial need of a category of patients. The statute specifically applies the prohibition to the Medicaid program – a program that is available only to financially needy persons. The inclusion of Medicaid within the prohibition demonstrates Congress' conclusion that categorical financial need is not a sufficient basis for permitting valuable gifts.

www.ChiroHealthUSA.com
Why ChiroHealthUSA?

As benefits for chiropractic care dwindle, more families are forced to choose between needed chiropractic care and other necessities. Because patients with insurance coverage have the benefit of the carrier negotiating the fees with the doctor, cash-paying patients, or those with non-covered services like Medicare beneficiaries, may have to pay MORE than insured patients. ChiroHealthUSA allows patients to use the membership concept they are already familiar with to access needed care for their immediate family.

Doctors are usually required to charge insurance companies and patients the same fees unless they are under a network contract for a lower fee. ChiroHealthUSA is a contracted network that allows doctors to set and accept discounts on their services for our members. When a patient joins ChiroHealthUSA, they are entitled to similar "in-network" discounts just like the insurance companies.

- A single $49 annual membership includes everyone in your immediate family.
- Partially insured patients who have coverage for some services and not others, like Medicare patients, may use their ChiroHealthUSA benefits to complement their existing benefits, specifically for the non-covered services.
- Patients may use their membership cards at more than 3,900 doctors in the network.

Medical Necessity in Medicare

Medicare National Carrier Determination (NCD)
"Medicare may only pay for items or services that are "reasonable and necessary" for the diagnosis or treatment of illness or injury to improve the ***functioning*** of a malformed body member."

Documentation must be legible

The Episode of Care”

“The Episode of Care” Model

Box 14:
Medicare –
Commercial Insurance –
PI/ Work Comp -

What is the Purpose of Chiropractic Care?

“Medicare may only pay for items or services that are “reasonable and necessary” for the diagnosis or treatment of illness or injury to improve the ***functioning*** of a malformed body member.”

Template for Medicare Initial Encounter Report REQUIRED

Symptoms causing patient to seek treatment
Family History
Past Health History
(Social History)
Mechanism of
Trauma
Quality and character of symptoms/problem
Onset, duration, intensity, frequency, location and radiation
Provoking and Palliative Factors
Prior interventions, treatments, medications, secondary complaints

Treatment Plan

- Recommended Level of Care
  Duration and frequency of visits
- Specific Treatment Goals
  What are you trying to accomplish?
- Objective measures to evaluate treatment effectiveness
  How do you know when the treatment has been accomplished?
- Care Plan

Evidence-Based Outcomes Assessment Tools

Why Outcomes Assessment?
- An objective measure of the patient's status
- Provides objective documentation regarding the patient's condition.
- Helps the doctor, patient and insurer to make *informed* decisions
- A deterrent to malpractice
- Backed up by refereed journals (JMPT, Spine)

Outcomes Assessment Tools
- Have patient complete on initial exam, on re-exam as clinically indicated and at any exacerbations.
- These tests *quantify* the amount of patient deconditioning present.
- A measure of the patient's **functional** impairment of activities of daily living.

Outcome Assessment Tests
- Visual Analog Scale
- Pain Drawings
- Revised Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability
- Neck Pain Disability Index Questionnaire
- Headache Disability Index
- Bournemouth Questionnaire – Cervical and Lumbar. "Lifestyle illnesses"
- Zung Psychological Assessment Questionnaire

Neck Pain Disability Index Score
0-8% = None
10-28% = Mild
30-48% = Moderate
50-68% = Severe
>70% = Crippled

Revised Oswestry Score:
0-5% = None
6-20% = Mild
20-40% = Moderate
40-60% = Severe
60-80% = Crippled
80%+ Bed Bound

*If you compare the original score to the score at re-examination, there must be a minimum of a 30% decrease in score to be clinically significant.

Assessment – What do you think?

- Provider records their professional opinions and judgments as to the patient's diagnosis, their progress and/or their functional limitations.
- You interpret the data presented in the objective portion of the note.
- You may also point out inconsistencies, justify your goals, discuss emotional status or indicate progress in therapy.
- You may also present reasons why certain information was not obtained or deferred.
- Recommendation of further tests or treatment that you think is necessary.
- Recommendation of referral to another provider.
- Do not introduce new data here.
- This is the area where you record *your* thought processes and concerns.

Medicare Medical Necessity

1. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services must have a direct therapeutic relationship to the patient's condition. (Medicare does not pay for pain).

2. You must have a reasonable expectation of recovery or improvement of function.

3. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. A diagnosis of pain is not sufficient for medical necessity

What is Medical Necessity? In your assessment, answer the following:
How is the patient improved?
Why does the patient still need care?

Acute subluxation - treatment for a new injury, identified by x-ray or physical exam. The treatment is expected to improve, arrest, or retard the patient's condition.

Chronic subluxation - A patient's condition is considered chronic when it is not expected to completely resolve (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the functional status has remained stable for a given condition, further manipulative treatment is considered maintenance therapy and is not covered.

An **acute exacerbation** is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Maintenance Therapy
▪Once MMI has been reached, Medicare will NOT pay for maintenance or supportive care.

____Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or_____maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature,the treatment is then considered maintenance therapy. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3A)

1.

2.

Modifiers

Medicare Modifiers

GY - Used when an item or service is **statutorily excluded** or does not meet the definition of any Medicare benefit. This modifier must be used when physicians, practitioners, or suppliers want to indicate that the item or service is **statutorily non-covered** (as defined in the Program Integrity Manual (PIM) or is not a Medicare benefit (as defined in the PIM). The use of this modifier will automatically signal Medicare's software to deny any service that is linked to this modifier.

- If the service is statutorily non-covered or is not a Medicare benefit, modifier GY may be used if the beneficiary insists on having Medicare billed.

GP – Services delivered under an outpatient physical therapy plan of care. As of January 1, 2018, the GP therapy modifiers are currently required to be appended to therapy services. In addition to the GP modifier, the GY modifier should also be appended. An example would be GPGY

GPGY – Services delivered under an outpatient physical therapy plan of care (97XXX) As of January 1, 2018, the GP therapy modifiers are currently required to be appended to therapy services. In addition to the GP modifier, the GY modifier should also be appended.
An example would be 97110GPGY

GZ - Used when an item or service is expected to be denied as not reasonable and necessary. This modifier must be used when physicians want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they *have not* had an Advance Beneficiary Notification (ABN) signed by the beneficiary.
If the beneficiary is not notified in writing that the provider expects that Medicare will deny the item or service, she/he cannot be held liable for the charges. The GZ modifier must be used to indicate that the provider expects that Medicare will deny an item or service as not reasonable and necessary and there had not been an ABN signed by the beneficiary.

GA - This modifier is used to indicate that a waiver of liability statement is on file. If the provider believes a service is likely to be denied by Medicare as not reasonable and necessary, the beneficiary must be so advised, in writing, prior to rendering of the service. The GA modifier must be used to indicate that the provider expects that Medicare will deny the service as not reasonable and necessary and the beneficiary has a signed Advance Beneficiary Notification (ABN) on file.

-AT Modifier
The –AT Modifier will be used with the CMT code in all acute and chronic subluxation (non-maintenance) spinal CMT cases.
If the AT modifier is not listed on the code, the CMT will be considered to be for maintenance.
The AT modifier is only to be appended to services that are part of active/corrective treatment.
The AT modifier should not be appended to services that are part of maintenance therapy.

The Advanced Beneficiary Notice Form (June 21, 2017)

Period of Effectiveness

- An ABN can remain effective for up to one year. ABNs may describe treatment of up to a year's duration, as long as no other triggering event occurs. If a new triggering event occurs within the 1-year period, a new ABN must be given.

See § 50.5 – Triggering Events.

1. One ABN for maintenance manipulation and one for non-covered services ("voluntary")
2. Good for up to one year
3. Signed copy to patient
4. Update as needed
5. *Personally* signed and dated by the patient

Red Flags of the ABN:
Name:

Identification Number:

Options:

Signature and Date:

The Treatment Plan

A. Treatment Goals
B. Frequency
C. Duration
D. Care Plan

1. Treatment Frequency and Duration

2. Treatment Goals
   a) Short-term Goals
      To decrease pain, spasms and edema
      Resolution of any radicular pain in the lower extremity
      Low back pain consistently less than or equal to 6/10 with all activities Resting low back pain with less than or equal to 2/10
      Independent with basic self-care ADL without increased low back pain

   b) Long-term Goals
      Address their ADL
      Low back pain at worst less than or equal to 4/10 with all activities
      Patient will ambulate 15 minutes at 2.0 miles per hour without increased low back pain Bilateral hip flexion, multifidus and gluteal strength to 4+ to 5/5
      Independent self-management
      To prepare the patient for a home-based exercise program

3. Care Plan
   Example:
   In the acute stage: manipulation, EMS (unattended), ice, pulsed ultrasound and patient education as indicated

   In the sub-acute stage: manipulation per palpation, skilled therapeutic rehabilitation exercise to improve functional capacity, strength and endurance and to decrease pain with ADL and patient education as indicated

Specific Treatment Goals

What are you trying to accomplish?

Objective measures to evaluate treatment effectiveness

How do you know when the treatment has been accomplished?

Recommended Level of Care

Duration and frequency of visits to accomplish the above goals

Sources:
www.Askmario.com

www.facebook.com/askmario - for Free

www.NCMIC.com

www.ChiroHealthUSA.com Free Webinars

- ***ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office*** by Dr. Mario Fucinari www.Askmario.com

New information posted regularly at www.facebook.com/askmario "Like" us

Medicare can now ask for records from up to FIVE years ago. Are you complaint? The OIG stated that a compliance plan (different from HIPAA) is a mitigating factor against fines and/or jail time. If you have a Compliance Plan done in keeping with the OIG Recommendations, it may be your bullet-proof vest!

For a *professionally* created Compliance manual, unique to your office or chart audits contact Mario Fucinari DC, CCSP, CPCO, a **Certified Professional Compliance Officer** for further information.

Our Services include:
Office Audit
Doctor and Staff Training (Front desk, billing, compliance and therapy training)
Chart Analysis
Billing Training
One-on-One Consultations
And More!! See our list of services at www.askmario.com or e-mail at doc@askmario.com

If you have questions…
www.AskMario.com
E-mail: Doc@AskMario.com

Thank You!!

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:

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

HEALTH INSURANCE CLAIM FORM

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

PICA | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (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)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 ______ 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 ______

PHYSICIAN OR SUPPLIER INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

A. 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								NPI	
2								NPI	
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) 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* OMB APPROVAL PENDING