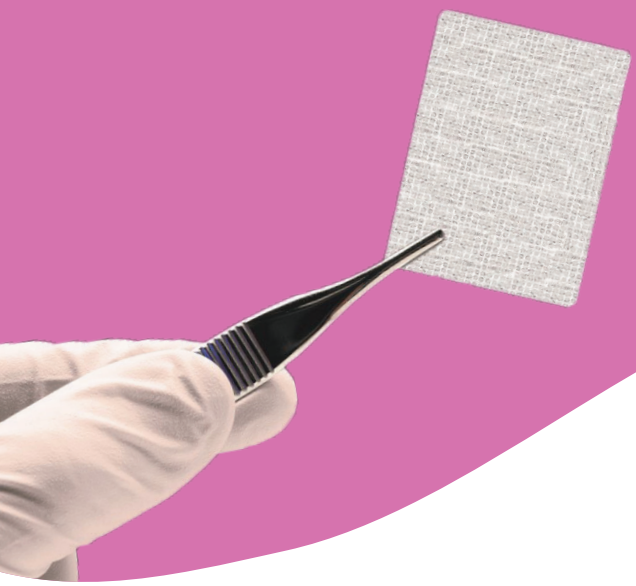
Smith+Nephew

GRAFIX PL PRIME◊
Lyropreserved
Placental Membrane

GRAFIX PRIME◊
Cryopreserved
Placental Membrane

GRAFIX CORE◊
Cryopreserved
Placental Membrane

# Reimbursement Guide **2022**
## Physician Office




**Reimbursement Hotline Services**
Phone: 866-988-3491
Fax: 866-304-6692

**Customer Support**
Phone: 888-674-9551

## Reimbursement Hotline Services

For assistance with reimbursement questions, contact Smith+Nephew Reimbursement Hotline Services Monday through Friday from 8:00 am - 7:00 pm EST at **1-866-988-3491**.

Smith+Nephew Reimbursement Hotline Services staff can assist with the following:

- Patient-specific insurance verifications
- Payer policy and Medicare Local Coverage Determination (LCD) information
- Nurse Case Manager review of documentation and coding
- Prior authorization and pre-determination support

To initiate insurance verification support for your patients, please submit a complete **Insurance Verification Request (IVR) Form** with a signed practitioner authorization and fax to **866-304-6692**. The provider is responsible for verifying individual contract or reimbursement rates with eachpayer. Smith+Nephew Reimbursement Hotline Services is not able to confirm contracted or reimbursable rateson your behalf.

## Reimbursement Disclaimer

Information on reimbursement in the U.S. is provided as a courtesy. Due to the rapidly changing nature of the law and the Medicare payment policy, and reliance on information provided by outside sources, the information provided herein does not constitute a guarantee or warranty that reimbursement will be received or that the codes identified herein are or will remain applicable. This information is provided “AS IS” and without any other warranty or guarantee, expressed or implied, as to completeness or accuracy, or otherwise. This information has been compiled based on data gathered from many primary and secondary sources, including the American Medical Association, and certain Medicare contractors. Providers must confirm or clarify coding and coverage from their respective payers, as each payer may have differing formal or informal coding and coverage policies or decisions. Providers are responsible for accurate documentation of patient conditions and for reporting of products in accordance with particular payer requirements.

# Advanced Therapy Documentation Checklist

**Prior to requesting insurance verification or prior authorization from a payer, the provider should have documentation of the following in the patient's medical record:**

- ☐ Diagnosis of a chronic wound and the causation or etiology *(i.e. Type II Diabetes)*

  *Primary (etiology) and Secondary (chronic ulcer) ICD-10 codes*

- ☐ Failure to respond to good standard wound care for ≥4 weeks *(Be specific about modalities such as debridement, advanced dressings, collagen, etc.)*

- ☐ Underlying disease or condition is being treated by licensed physician and is under control:

  *Diabetes – HbA1c <12%*

  *Venous stasis – adequate compression therapy to control edema*

- ☐ Blood perfusion is adequate (ABI ≥0.65 or toe pressure ≥30 mmHg, pedal pulse)

- ☐ Venous reflux studies for venous stasis ulcer diagnosis

- ☐ Patient is compliant with off-loading for DFU or compression for VLU *(document type)*

- ☐ Absence of acute wound infection or active osteomyelitis – must state in the record

  *If the patient has a history of osteomyelitis, recent X-rays are negative for active osteomyelitis and the patient's chart documents stating the osteomyelitis is not active*

- ☐ For patients with history of Charcot neuroarthropathy, include documentation that acute Charcot Foot is not present, and any history of acute Charcot Foot has been treated

- ☐ Weekly wound measurements taken; wound size is ≥1 cm2 when initiating therapy

- ☐ Smoking Status – smokers have been educated that smoking impairs wound healing, counseled to stop, and provided cessation resources to curb smoking

- ☐ The patient is adequately nourished to support wound healing

- ☐ Documented treatment plan; to include the use of advanced therapies

Osiris THERAPEUTICS, INC.
is now part of
Smith+Nephew

# Smith+Nephew Reimbursement Hotline Services
## Insurance Verification Request (IVR) Form
**Phone:** 866-988-3491 **Fax:** 866-304-6692

### 1.Type of Insurance Verification Requested

☐ New Wound ☐ Additional Applications ☐ Re-Verification ☐ New Insurance ☐ Check Out-Of-Pocket Maximum

If **prior authorization** is required, I authorize Smith and Nephew to initiate the authorization.
**Please select one:** ☐ **Yes** ☐ **No**
***If yes, please attach all clinical notes related to the wound treatment episode.***

☐ **Single Wound**
☐ **Multiple Wounds**

**Application Date:** ____/ ____/ ____

### 2. Patient Information: *Please list the patient's name on this form when attaching a face sheet*

| First Name: | Last Name: | | | M.I.: |
|---|---|---|---|---|
| Address: | Apt./Suite#: | City: | State: | Zip: |
| Date of Birth: | Gender: ☐ Female ☐ Male | Phone #: | | |

### 3. Insurance Information: *Please attach a copy (front & back) of patient's insurance card(s)*

| Cardholder Name/Relationship: | | Date of Birth: |
|---|---|---|
| **Primary Payer:** | | Plan Type: |
| Policy #: | Group #: | Card Phone #: |
| **Secondary Payer:** | | Plan Type: |
| Policy #: | Group #: | Card Phone #: |
| **Tertiary Payer:** | | Plan Type: |
| Policy #: | Group #: | Card Phone #: |

### 4. Healthcare Provider (HCP) & Facility Information: *Please note, we do not verify inpatient benefits*

**Place of Service:** ☐ Physician Office (POS11) ☐ Hospital Outpatient Department (POS19/22) ☐ Ambulatory Surgery Center (POS24)

☐ Home Visit (POS12) ☐ Assisted Living Facility (POS13) ☐ Unskilled Nursing Bed (POS32) ☐ Other POS: _____

***NOTE: Select only ONE POS. It is the provider's responsibility to confirm POS and skilled vs. unskilled status***

| HCP First Name: | HCP Last Name: | M.I.: |
|---|---|---|
| HCP NPI: | HCP Tax ID#: | Specialty: ☐ MD ☐ DO ☐ DPM ☐ PA ☐ NP/FNP ☐ Other: _____ |
| Contact Name: | Phone #: | |
| Facility Name: | | Facility NPI: |
| Facility Address: | | Facility Tax ID: |
| City, State, Zip: | Phone #: | Fax #: |

### 5. Treatment Information: *May select up to FOUR products with corresponding CPT application code groups*

☐ **GRAFIX PL PRIME◇ (Q4133)** ☐ **GRAFIX PRIME◇ (Q4133)** ☐ **GRAFIX CORE◇ (Q4132)**
☐ **OASIS® Wound Matrix (Q4102)** ☐ **OASIS® Burn Matrix (Q4103)** ☐ **OASIS® ULTRA Tri-Layer Matrix (Q4124)**

**CPT:**
**Legs/Arms/Trunk ≤ 100 sq cm:** ☐ 15271/15272-C5271/C5272 **Legs/Arms/Trunk ≥ 100 sq cm:** ☐ 15273/15274-C5273/C5274
**Feet/Hands/Head ≤ 100 sq cm:** ☐ 15275/15276-C5275/C5276 **Feet/Hands/Head ≥ 100 sq cm:** ☐ 15277/15278-C5277/C5278

***NOTE: Prior use of skin substitutes or global periods related to the the same wound may impact reimbursement***

### 6. Wound Information & Diagnosis Code(s): *Please include codes that indicate etiology, ulcer type, AND location*

| **ICD-10 Codes: #1 Wound (Required)** | **ICD-10 Codes: #2 Wound (*Required)** | **ICD-10 Codes: #3 Wound (*Required)** |
|---|---|---|
| Primary (Etiology): _____ | Primary (Etiology): _____ | Primary (Etiology): _____ |
| Secondary (Ulcer/Location): _____ | Secondary (Ulcer/Location): _____ | Secondary (Ulcer/Location): _____ |
| Tertiary (Optional): _____ | Tertiary (Optional): _____ | Tertiary (Optional): _____ |
| **Wound #1 Size:** L ____ W ____ D____ | **Wound #2 Size:** L ____ W ____ D ____ | **Wound #3 Size:** L ____ W ____ D ____ |

***If intending to treat more than one wound, please provide diagnosis codes for each additional wound***

### 7. Healthcare Provider Signature: *Please include all required information and sign below*

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form permitting me to release the patient's protected health information (PHI) to the Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to GRAFIX PL◇/GRAFIX◇ and/or OASIS® Matrix products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge.
**For typed signatures below:** I agree that this typed signature has the same validity and meaning as my handwritten signature.

**HCP Signature:** _____ **Date:** _____

Disclaimer: The Smith+Nephew Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Smith & Nephew disclaims liability for payment of any claims, benefits or costs.

# CPT Procedure Codes and Medicare Payments

Medicare has designated specific CPT codes (15271-15278) for qualified healthcare providers to report the application of skin substitute graft procedures when applying CTPs/ skin substitute products. The selection of the code is based upon the location and size of the defect. Ensure the medical record reflects these elements and a procedure description including the fixation method.

Physicians applying Cellular and/or Tissue-Based Products (CTPs) in the office setting should report both the Current Procedural Terminology (CPT) application code(s) and the applicable GRAFIX◊ Membrane product Healthcare Common Procedural Coding System (HCPCS) codes when submitting claims—**Q4133 for GRAFIX PRIME◊ and GRAFIX PL◊, Q4132 for GRAFIX CORE◊.**

| Coding | | Non-Facility (Physician Office) Rate | Facility (HOPD) Rate |
|---|---|---|---|
| **CPT Codes** | **Code Description** | **2022 Medicare National Avg. Payment** | **2022 Medicare National Avg. Payment** |
| 15271 | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | $159.88 | $85.13 |
| +15272 | Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | $25.95 | $18.00 |
| 15273 | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | $327.72 | $201.41 |
| +15274 | Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | $86.86 | $46.37 |
| 15275 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | $164.38 | $94.82 |
| +15276 | Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | $33.57 | $25.95 |
| 15277 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | $359.56 | $229.44 |
| +15278 | Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | $100.36 | $57.79 |

**Important Notes**: The Medicare payment amounts listed do not reflect adjustments for deductible, copayments, coinsurance, sequestration or any other reductions. All payment amounts listed are based on national averages and will vary by geographical locations.

# Product HCPCS Codes and Modifiers

**GRAFIX◊ HCPCS Codes, UPC Codes and Billing Units:**

All GRAFIX Membranes are billed per square centimeter. One billable unit is 1 $cm^2$.
To calculate the number of billable units multiply the length by the width of the wound cover that was applied. The below chart lists the assigned HCPCS codes for GRAFIX Membranes and the billable units per product size.

In general, skin substitutes are reimbursed by Medicare based on the Average Sales Price (ASP) published quarterly by CMS on the cms.gov website under the ASP Drug Pricing File. The ASP rate is per square centimeter. In the absence of a published ASP by CMS, a product will be reimbursed based off Invoice or List Price (see Important Notes below). Please ask your GRAFIX Sales Representative or FRM for the currently effective ASP or List Price. Providers must check contracted payment rates for private insurers.

| Preservation and Storage | Product Description | Part Number | UPC Code | Billing Units (per sq cm) | HCPCS Q-Code |
|---|---|---|---|---|---|
| Lyopreserved and stored at room temperature | GRAFIX PL PRIME◊ 16 mm Disc (2 $cm^2$) | PS13016 | 859857003395 | 2 | Q4133 |
| | GRAFIX PL PRIME 1.5 x 2 cm (3 $cm^2$) | PS13015 | 859857003388 | 3 | Q4133 |
| | GRAFIX PL PRIME 2 x 3 cm (6 $cm^2$) | PS13023 | 859857003371 | 6 | Q4133 |
| | GRAFIX PL PRIME 3 x 3 cm (9 $cm^2$) | PS13033 | 859857003449 | 9 | Q4133 |
| | GRAFIX PL PRIME 3 x 4 cm (12 $cm^2$) | PS13034 | 859857003364 | 12 | Q4133 |
| | GRAFIX PL PRIME 5 x 5 cm (25 $cm^2$) | PS13055 | 859857003357 | 25 | Q4133 |
| Cryopreserved and stored at -75°C to -85°C | GRAFIX PRIME◊ 16 mm Disc (2 $cm^2$) | PS60013 | 859857003340 | 2 | Q4133 |
| | GRAFIX PRIME 1.5 x 2 cm (3 $cm^2$) | PS11015 | 859857003081 | 3 | Q4133 |
| | GRAFIX PRIME 2 x 3 cm (6 $cm^2$) | PS11023 | 859857003067 | 6 | Q4133 |
| | GRAFIX PRIME 3 x 4 cm (12 $cm^2$) | PS11034 | 859857003074 | 12 | Q4133 |
| | GRAFIX PRIME 5 x 5 cm (25 $cm^2$) | PS11055 | 859857003098 | 25 | Q4133 |
| | GRAFIX CORE◊ 1.5 x 2 cm (3 $cm^2$) | PS12015 | 859857003104 | 3 | Q4132 |
| | GRAFIX CORE 2 x 3 cm (6 $cm^2$) | PS12023 | 859857003050 | 6 | Q4132 |
| | GRAFIX CORE 3 x 4 cm (12 $cm^2$) | PS12034 | 859857003111 | 12 | Q4132 |
| | GRAFIX CORE 5 x 5 cm (25 $cm^2$) | PS12055 | 859857003128 | 25 | Q4132 |

**Important Notes:**
1. CMS instructions indicate that payment for drugs and biologicals that are not included in the ASP File are based on the published wholesale acquisition cost (WAC) or invoice price. The payment limit is typically 103 to 106 percent of the lesser of the lowest priced brand or median generic WAC. Physician offices should verify if the Medicare Administrative Contractor (MAC) that processes their claims, covers the product and whether the MAC pays for it based on WAC or invoice price.

a. If the MAC pays for the product based on WAC, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
- o Product name
- o NDC code
- o WAC of product
- o WAC per sq. cm.
- o Source of the WAC (e.g., Red Book)

b. If the MAC pays for the product based on invoice price, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
- o Product name
- o Product size (in sq. cm.)
- o Product number
- o Invoice price per piece
- o Shipping cost

2. The Medically Unlikely Edit (MUE) is the maximum units of a product reimbursed in one application per day. The MUE for GRAFIX◊ Membrane products areas follows: a. MUE for GRAFIX CORE◊ (Q4132) = 50 units. b. MUE for GRAFIX PL PRIME◊ and GRAFIX PRIME◊ (Q4133) = 113 units. Note: MUE data as of 2019.

3. Payers including some MACs will require use of certain modifiers. Please check with the patient's insurance plan or MAC to identify whether modifiers are required with Q4132 or Q4133.

a. Common Modifiers:
- i. JC – skin substitute used as a graft
- ii. JD – skin substitute not used as a graft
- iii. JW – discarded skin substitute, not used (wastage)

# ICD-10 Diagnosis Code Guidelines for Wound Care

GRAFIX PL◊ and GRAFIX◊ Membrane coverage is based on medical necessity and subject to payer coverage guidelines. For most payers, GRAFIX PL and GRAFIX Membrane are considered medically necessary as an adjunct in the treatment of chronic ulcers that fail to progress toward healing after a period of standard wound care. Providers should always follow payer coverage guidelines for covered indications. Examples of common lower-extremity chronic wounds include:

- Diabetic foot ulcers (DFU) / diabetic ulcers of the lower extremities (ankle)
- Venous stasis ulcers (VSU) / venous leg ulcers (VLU)
- Pressure ulcers
- Chronic non-healing surgical or trauma wounds of the lower extremity with co-morbidities

It is recommended that providers select the most specific primary and secondary diagnosis codes to accurately describe the reason the wound is not healing properly, and codes that indicate the wound is chronic and describe the location, severity, and laterality.

**Example of specific DFU codes:**

- Primary diagnosis: E11.621, *type 2 diabetes mellitus with a foot ulcer*
- Secondary diagnosis: L97.522, *non-pressure chronic ulcer of other part of left foot with fat layer exposed*

**Example of specific VLU codes:**

- Primary diagnosis: I87.312, *chronic venous hypertension (idiopathic) with ulcer of left lower extremity*
- Secondary diagnosis: L97.222, *non-pressure chronic ulcer of left calf with fat layer exposed*

These codes are provided for information only and are not a statement or guarantee of reimbursement. The provider is ultimately responsible for verifying coverage with the patient's payer source.

The ICD-10 codes listed below represent some of the etiology diagnosis codes commonly associated with causes of lower extremity chronic ulcers. This is not meant to be an exhaustive list. Codes were selected from internal benefit investigation data and represent the most common codes submitted to the S+N Reimbursement Hotline.

**Common ICD-10 Codes Associated with Chronic Lower Extremity Ulcers**

| Code | Decription |
|---|---|
| | **Diabetic Ulcer Codes (not meant to be an exhaustive list)** |
| E10.621 | Type 1 diabetes mellitus with **foot ulcer** |
| E10.622 | Type 1 diabetes mellitus with other **skin ulcer** |
| E11.621 | Type 2 diabetes mellitus with **foot ulcer** |
| E11.622 | Type 2 diabetes mellitus with other **skin ulcer** |
| E13.621 | Other specified diabetes mellitus with **foot ulcer** |
| | **Venous Ulcer Codes (not meant to be an exhaustive list)** |
| I83.012 | Varicose veins of **right** lower extremity with ulcer of **calf** |
| I83.013 | Varicose veins of **right** lower extremity with ulcer of **ankle** |
| I83.014 | Varicose veins of **right** lower extremity with ulcer of **heel & midfoot** |
| I83.015 | Varicose veins of **right** lower extremity with ulcer of **other part of foot** |
| I83.018 | Varicose veins of right lower extremity with ulcer of other part of lower leg |
| | **Non-Pressure Chronic Ulcer of Lower Limb** |
| L97.211 | Non-Pressure Chronic Ulcer of **right** calf limited to breakdown of skin |
| L97.212 | Non-Pressure Chronic Ulcer of **right** calf with fat layer exposed |
| L97.221 | Non-Pressure Chronic Ulcer of **left** calf limited to breakdown of skin |
| L97.222 | Non-Pressure Chronic Ulcer of **left** calf with fat layer exposed |
| L97.311 | Non-Pressure Chronic Ulcer of **right** ankle limited to breakdown of skin |

Please see the product's Instructions for Use (IFU) for indications, contraindications, warnings, precautions and other important information.

**Advanced Wound Management**
Smith+Nephew, Inc.
Fort Worth, TX 76109 USA



Oasis is manufactured by:
Cook Biotech, Inc.
1425 Innovation Place
West Lafayette, IN 47906

Oasis is distributed by:
Advanced Wound Management
Smith & Nephew Inc.
Fort Worth, TX 76109

Customer Care Center:
T 888-674-9551
F 443-283-4419

www.smith-nephew.com
www.grafixpl.com

# HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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? PLACE (State) YES NO

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

GRAFIX PL PRIME (5 x 5) per sq cm

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

A. E11.621 B. L97.522

E. F.

I. J. K. L.

22. RESUBMISSION ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

Service Description

Primary and Secondary ICD-10 Codes

Product & Procedure Charges

| 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 | $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 01 | 01 | 19 | 01 | 01 | 19 | 11 | | 15275 | | A, B | | 1 | | NPI |
| 2 | 01 | 01 | 19 | 01 | 01 | 19 | 11 | | Q4133 | | A, B | | 25 | | NPI |
| 3 | | | | | | | | | | | | | | | NPI |
| 4 | | | | | | | | | | | | | | | NPI |
| 5 | | | | | | | | | | | | | | | NPI |
| 6 | | | | | | | | | | | | | | | NPI |

CPT Code

HCPCS Code

Billing Units

Date of Service

PHYSICIAN OR SUPPLIER INFORMATION

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.