REIMBURSEMENT GUIDE

Posterior Segment OCT

This guide is intended to provide coding and billing information valid from **January 1, 2011**. Reimbursement codes and billing practices change over time. All information is subject to the descriptions and disclaimers contained in this guide.

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Introduction: The SPECTRALIS® Imaging System

The SPECTRALIS imaging system is a multi-modality platform that provides high resolution imaging of the retina and other ocular structures to facilitate disease diagnosis and monitoring. The SPECTRALIS system is available in various models with different combinations of imaging modalities as listed in Table 1 below.

Table 1 - SPECTRALIS Imaging Modalities

	HRA+OCT	FA+OCT	HRA	OCT PLUS with BluePeak	OCT PLUS	OCT with BluePeak	OCT
Optical coherence tomography	✓	✓		✓	✓	✓	✓
Infrared imaging	✓	✓	✓	✓	✓	✓	✓
Fluorescein angiography	✓	✓	✓				
ICG angiography	✓		✓				
Iris angiography	✓	✓	✓				
External photography	✓	✓	✓	✓	✓	✓	✓
BluePeak blue laser autofluorescence	✓	✓	✓	✓		✓	
Red-free photography	✓	✓	✓				
Fundus photography	✓	✓	✓	✓	✓	✓	✓

This reimbursement guide is intended to:

- Provide an overview of the current coverage, coding, and billing landscape for ophthalmologic applications of OCT using the SPECTRALIS; and
- Equip health care providers with the information and tools to obtain reimbursement from Medicare and other third-party payers for these services.

Disclaimer

The information provided in this guide contains general reimbursement information only and is not legal advice nor is it advice about how to code, complete, or submit any particular claim for payment. The information provided represents Heidelberg Engineering's understanding of current reimbursement policies. It is the health care provider's responsibility to determine appropriate codes, charges, and modifiers, and submit bills for the services consistent with the patient's insurer requirements. Third-party payers may have different policies and coding requirements. Such policies can change over time. Heidelberg Engineering disclaims any responsibility for claims submitted by health care providers. Health care providers should check and verify current policies and requirements with the payer for any particular patient that will be using the SPECTRALIS imaging system.

1 Coverage

Coverage refers to whether a product or service would be reimbursed by a payer, and the conditions or restrictions under which it would be paid.

In general, payers provide coverage for services when they are medically reasonable and necessary for the treatment or diagnosis of illness or injury. In most cases, statements and conditions of coverage for a particular service are communicated in coverage policies that each payer develops according to their own methods and criteria. As coverage policies typically vary by payer, health care providers are strongly encouraged to contact individual payers as needed to verify whether a service is covered, as well as any coverage guidelines or restrictions that may be in place.

Optical Coherence Tomography (OCT)

Medicare Coverage

There is no single national coverage policy for ophthalmologic applications of OCT. However, some Medicare contractors have published Local Coverage Determinations (LCDs) stipulating various patient diagnoses that would justify coverage of this technology.

As of April 2011, the following Medicare contractors have published LCDs on OCT:

- Cigna Government Services (ID)
- First Coast Service Options (FL, PR, VI)
- Highmark Medicare Services (DE, DC, MD, NJ, PA)
- National Government Services (CT, NY)
- National Heritage Insurance Company (ME, MA, NH, RI, VT), Palmetto GBA (SC, NC)
- Wisconsin Physician Services (IA, KS, MO, NE).

To determine if OCT would be covered for a particular condition, please refer to your local Medicare contractor's LCD to identify if there are any covered International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that would appropriately describe the patient's specific condition. If so, utilization of OCT for this indication may then be covered under the existing policy. It is the health care provider's responsibility to report the ICD-9-CM diagnosis code(s) that most accurately describe(s) the patient's disease state.

Table 2. Steps to Determine Medicare Coverage for OCT

Steps to Determine Medicare Coverage for OCT	
1	Go to the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx to access the Medicare Coverage Database.
2	Search for the LCD relevant to your state or geographic area, using "92133" or "92134" as the CPT/HCPCS code criteria.
3	Within the relevant LCD, locate the list of "ICD-9 codes that support medical necessity" and identify if there are any diagnosis codes that match the patient's specific condition. If so, your local Medicare contractor will likely cover OCT for that particular patient.

In the absence of an LCD for OCT, Medicare will cover the procedure according to the medical necessity of an individual case. It is recommended that health care providers document the following in the patient's medical record as evidence to support coverage: the patient's condition, medical history, and reason for the service. Specific documentation guidelines are typically included in each LCD. If you require additional guidance on documentation requirements for OCT in the absence of an LCD, please contact your local Medicare contractor.

Private Payer Coverage

Most private payers do not have published coverage policies for OCT. For these payers, coverage will be based on determinations of medical necessity on a case-by-case basis. Health care providers should document in the patient's medical record their condition, medical history, and reason for the service as evidence to support coverage.

For the handful of private payers that have published coverage policies on OCT, health care providers may select the appropriate ICD-9-CM diagnosis code(s) that accurately describe(s) the patient's disease state. As coverage guidelines vary by payer, please refer to individual private payer policies to identify the relevant list of covered diagnoses for a given payer.

In the event of a claim denial, health care providers can opt to file an appeal with the payer. Success in overturning denials will then be dependent on justifying the medical necessity of the procedure in each specific case. For more information on submitting appeals, please refer to Chapter 4: *Appeals*.

ICD-9-CM Diagnosis Codes Supporting Medical Necessity

Table 3 includes some, but not necessarily all, of the common ICD-9-CM diagnosis codes for ophthalmologic disorders that may justify coverage of OCT.

Not all of the codes in this list may apply to a given payer. Please refer to individual Medicare LCDs and private payer coverage policies to identify the appropriate list of covered diagnoses for a specific payer. It is ultimately the health care provider's responsibility to report the ICD-9-CM diagnosis code(s) that most accurately describe the patient's condition.

Table 3. ICD-9-CM Diagnosis Codes Commonly Covered for OCT

ICD-9-CM Code	Code Description
115.02	Histoplasma capsulatum retinitis
115.12	Histoplasma duboisii retinitis
115.92	Histoplasmosis retinitis unspecified
190.3	Malignant neoplasm of conjunctiva
190.5	Malignant neoplasm of retina
190.6	Malignant neoplasm of choroid
224.5	Benign neoplasm of retina
224.6	Benign neoplasm of choroid
224.8	Benign neoplasm of other specified parts of eye
249.50 - 249.51	Secondary diabetes mellitus with ophthalmic manifestations
250.50 - 250.53	Diabetes with ophthalmic manifestations
360.11	Sympathetic uveitis
360.21	Progressive high (degenerative) myopia
360.30 - 360.34	Hypotony of eye
361.0 - 361.9	Retinal detachments and defects
362.01 - 362.85	Other retinal disorders
363.00 - 363.72	Chorioretinal inflammations, scars, and other disorders of choroid
364.73	Goniosynechiae
365	Glaucoma
368.11	Sudden visual loss
368.14	Visual distortions of shape and size
368.40 - 368.45	Visual field defects
368.55	Acquired color vision deficiencies
376.00 - 376.9	Disorders of the orbit
377.0 - 377.9	Disorders of optic nerve and visual pathways
379.11 - 379.29	Scleral ectasia - Other disorders of vitreous
743.57	Specified congenital anomalies of optic disc
743.58	Vascular anomalies congenital
743.59	Other congenital anomalies of posterior segment
854.00 - 854.19	Intracranial injury of other and unspecified nature
921.3	Contusion of eyeball

2 Coding and Billing

Coding refers to the standardized numeric and alpha-numeric systems that are used to identify specific items and procedures furnished to a patient.

Billing refers to the submission of these codes on claim forms for adjudication by the payer and subsequent reimbursement to the provider.

There is a variety of coding systems currently in use. When billing third-party payers for an episode of care, health care providers prepare claim forms by listing codes that report the patient's condition (ICD-9-CM diagnosis codes), procedures performed (Current Procedural Terminology (CPT®[1]) codes), and items furnished (Healthcare Common Procedure Coding System (HCPCS) codes).

Although these coding systems are nationally recognized and employed, in some cases coding guidelines may vary by payer. Therefore, health care providers are strongly encouraged to contact individual payers as needed to verify their specific coding guidelines for a particular service.

[1] CPT is a registered trademark of the American Medical Association. © 2011 AMA. All rights reserved.

Billing for OCT

Effective January 1, 2011, there are two distinct CPT codes available to report posterior segment OCT imaging. They individual codes were created to distinguish between imaging of the optic nerve head and of the retina. The codes are:

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment**, with interpretation and report, unilateral or bilateral; **optic nerve**

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment**, with interpretation and report, unilateral or bilateral; **retina**

Both of these codes are intended to report unilateral OR bilateral procedures. This means that for each code, only one unit should be reported for a single patient encounter, regardless of whether the procedure is performed on one or both eyes.

Using Modifiers

CPT modifiers are two-letter or two-digit codes that may be appended to CPT codes on claim forms in order to convey additional information regarding the procedure(s) performed by the health care provider. Proper use of modifiers is necessary for accurate billing, and it is the responsibility of the health care provider to determine which modifier(s), if any, may be applicable in a given scenario.

Table 4 below lists some of the common modifiers that may apply to OCT imaging.

Table 4. Common Modifiers for OCT Imaging

Modifier	Explanation
-RT	Right eye is imaged
-LT	Left eye is imaged
-59	Distinct procedural service – to identify procedures, other than E/M services, that are not normally reported together, but are appropriate under the clinical circumstances
-TC	Technical component – when billing for ONLY the actual taking of the image, the equipment, and the technology
-26	Professional component – when billing for ONLY the analysis and interpretation of the image obtained

Because CPT 92133 and 92134 describe both unilateral *and* bilateral procedures:

1. If OCT is performed on ***both*** eyes, bill either 92133 or 92134 as a single line item with a unit count of one.
2. If OCT is performed on ***one*** eye, bill either 92133 or 92134 as a single line item with a unit count of one, and append the –RT or –LT modifier to indicate which eye was imaged.

In the event that only the technical or professional component of OCT is performed, health care providers can bill for the service by appending the -TC or -26 modifier, respectively, to CPT 92133 or 92134.

To view a sample claim form for OCT imaging, please refer to Appendix A.

Please note that the sample claim forms provided in this reimbursement guide are NOT inclusive of all applicable codes that may be reported for a single patient encounter. It is the responsibility of the health care provider to document and code appropriately for services performed at all times.

Documentation Guidelines

Both Medicare and private payers generally require that health care providers maintain some form of documentation in the patient's medical record to justify the medical necessity of OCT. Although payers may not instruct health care providers to submit the supporting documentation with every claim for these services, they may request this information at any time to facilitate a determination of medical necessity.

The specific documentation guidelines for OCT will vary by payer, but some common requirements are:

- Relevant patient medical history, including progress notes supporting the ICD-9-CM diagnosis code(s) selected (e.g., description of patient complaints or symptoms)
- Relevant prior diagnostic testing and completed report(s), including any previous OCT results or fundus images when appropriate

Table 5 lists additional documentation that may be requested for OCT.

Table 5. Additional Documentation Requirements for OCT Imaging

OCT
• Copy of the test results and computer analysis of the data

Please refer to individual Medicare LCDs or private payer coverage policies to verify documentation requirements for a particular payer. In the absence of LCDs or coverage policies for OCT imaging, please contact the payer directly to obtain additional guidance.

National Correct Coding Initiative (NCCI) Edits

Medicare's NCCI edits identify procedure code pairs that cannot be billed together for the same patient on the same date of service because it would be medically unlikely or unnecessary to do so. The goal of these edits is to prevent improper payment when incorrect code combinations are reported.

While these edits are maintained by CMS and used by Medicare, private payers typically have similar coding edits in their claims processing systems. Please note that the following information is specific to Medicare policy; health care providers should contact individual private payers as needed to confirm their correct coding guidelines for OCT imaging.

CPT 92133 + 92134

Under current NCCI edits, OCT of the optic nerve (92133) and retina (92134) cannot be billed together for the same patient on the same date of service under any circumstances. In the event that these two codes are billed together for the same patient encounter, only CPT 92133 would be paid, and CPT 92134 would be denied.

CPT 92133/92134 + 92250

While both OCT and infrared/red-free fundus imaging may be used in the diagnosis and/or monitoring of ophthalmic disorders, NCCI edits do not typically allow CPT 92133 or 92134 (OCT) and 92250 (fundus imaging) to be paid for the same patient encounter. In the event that both services are billed together, only CPT 92133 or 92134 would be eligible for payment, and CPT 92250 would be denied.

However, in certain situations where it may be medically necessary to perform both OCT and fundus imaging during the same patient encounter, both procedures may be paid if an appropriate modifier is appended and supported by additional clinical documentation.

CPT 92133/92134 + 92499

Some payers such as Trailblazer (Medicare) may require infrared/red-free fundus imaging to be billed using CPT 92499 instead of 92250. In this case, while there are no NCCI edits specifically for the code pairs consisting of CPT 92133/92134 and 92499, the presence of the unlisted code 92499 on the claim form would likely trigger manual review of the claim by the payer. Therefore, if both CPT codes are billed together for the same patient encounter, it would be up to the discretion of the payer to determine whether one or both codes can be paid.

For more information on the comprehensive set of NCCI edits for OCT imaging, please refer to the CMS website at http://www.cms.gov/NationalCorrectCodInitEd/.

3 Reimbursement

Reimbursement refers to the process by which health care providers are paid for the items and services furnished to a patient during an episode of care.

Under Medicare guidelines, physicians are reimbursed for their professional services according to the Medicare Physician Fee Schedule (MPFS), which aligns payment rates to individual CPT/HCPCS codes. In contrast, private payers may use a wide variety of reimbursement methodologies to pay physicians for the services provided to their beneficiaries, including fee-for-service, percent of billed charges, capitation, etc.

To ensure proper reimbursement, health care providers should document and code appropriately for services performed and/or items furnished at all times.

Reimbursement systems and rates are subject to change over time. Please check with individual payers as needed to obtain the most up-to-date payment information.

Medicare Physician Payments

Current calendar year (CY) 2011 MPFS payment rates for OCT imaging are provided below in Table 6. Keep in mind that while these rates represent national base payments, actual reimbursement amounts will vary by location due to adjustments for geographic differences.

Table 6. 2011 Medicare Physician Payment Rates for OCT Imaging

CPT Code	Code Descriptor	Component	2011 Medicare Physician Fee Schedule
OCT			
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Global*	$44.51
		TC†	$15.29
		26‡	$29.22
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Global	$44.51
		TC	$15.29
		26	$29.22

† *TC* – Technical component
‡ *26* – Professional component
* *Global* – Sum of technical and professional components

The "unilateral or bilateral" status of the new CPT codes for OCT has significant implications for provider reimbursement. Since only one unit of CPT 92133 or 92134 can be billed for unilateral or bilateral OCT, this means that a physician would receive the same payment amount regardless of whether the procedure is performed on one or both eyes.

Private Payer Physician Payments

As mentioned at the beginning of this chapter, there are no standardized methodologies that private payers use to determine payment amounts for physician services. Please check your service contracts with individual private payers or contact each payer directly to verify the applicable reimbursement methodologies and/or amounts for OCT imaging.

4 Appeals

An appeal is a request by the patient or provider for the payer to review a denied claim or service and consider overturning the denial and reimbursing the claim or service.

When a claim is submitted to a payer, the payer will either approve the claim for payment or deny it. In general, claims may be denied for two reasons: technical billing errors or lack of documented medical necessity. Technical billing errors refer to administrative mistakes on the claim form, such as reporting the wrong number of units or forgetting to list the diagnosis code. On the other hand, medical necessity denials typically arise when the payer considers a technology to be experimental/investigational and therefore non-covered, or when they believe that there is a lack of supporting documentation that demonstrates the medical necessity of the service for the particular patient in question.

The appeals process allows health care providers to request reconsideration of a denied claim, with the ultimate goal of obtaining payment for the service billed. While the requirements and timelines for this process will vary for each individual payer, most payers offer at least two levels of appeal, with decisions made at the final level of appeal usually considered binding.

Managing Claim Denials

In the event that you receive a denied claim for OCT imaging performed using the SPECTRALIS, review the Explanation of Benefits (EOB) sent by the payer (or Medicare Summary Notice if the patient is a Medicare beneficiary) to identify the specific reason for denial.

- If the payer is requesting additional information in order to adjudicate the claim, submit the necessary documentation according to the payer's instructions.
- If the claim was denied due to technical billing errors (e.g., incorrect modifier, missing diagnosis code), correct the claim form and resubmit to the payer for processing.
- If the claim was denied due to lack of medical necessity, consider filing an appeal according to the payer's specific guidelines.

Appealing Denials

Verify the Payer's Appeals Process

If you decide to appeal a denied claim, it is important to note that individual payers have different appeals processes. Therefore, the first step in filing an appeal should be to contact the payer in question to verify their specific administrative requirements and timelines. Some payers may utilize a standard appeal form or require a written letter to initiate an appeal – it will be important to identify such factors before beginning the process.[2]

Following are some key questions to ask to obtain a complete picture of a payer's appeals process:

- Does the appeal have to be filed by the patient or the health care provider?
- Is there a particular form that needs to be completed?
- How many levels of appeal are allowed?
- What is the administrative process at each level of appeal?
- What are the deadlines for requesting an appeal?
- Where and how should appeals be sent?
- What type of supporting documentation should be submitted for a medical necessity appeal?
- Who is the appropriate point of contact with whom to follow up on an appeal?
- When can a response on the appeal be expected?

Prepare an Appeal Letter

If the payer does not use a standard appeal form, draft an appeal letter summarizing why you believe the denied service should be covered for the patient.

The letter should specify the reason for appeal (as listed in the EOB or denial letter received from the payer) and clearly identify the medical necessity of the service provided within the context of each patient's unique situation.

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[2] The Medicare appeals process is standardized across all regional contractors. For more information, please visit the CMS website at http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.

Assemble the Appeal Packet

Aside from the appeal letter, appeal packets typically include additional supporting materials to document the medical necessity of the service provided.

One of the key components of an appeal packet is a letter of medical necessity signed by the ordering physician that clearly describes the condition(s) justifying the service provided to the patient.
The documentation listed below is an example of the other types of information that may be submitted to support an appeal for OCT imaging performed on the SPECTRALIS:

- Physician order for the service
- Patient's medical history relevant to the indicated diagnosis
- OCT test results
- Physician interpretation and report of diagnostic results
- Relevant clinical literature

Submit the Appeal Packet

Once the appeal packet has been assembled, it should be submitted to the payer according to their specific guidelines. The following are some tips to ensure that your appeal is successfully submitted:

- Before sending, verify that the appeal packet is correctly addressed to the payer's appeals department
- When possible, obtain a fax number for the payer's appeals department and send a copy of all documents via fax as well
- Contact the payer's appeals department one week after submission to confirm that your appeal was received; if not received by that time, check back periodically until confirmation is given

If you are not satisfied with the outcome of an appeal at a particular level, you may consider elevating the appeal to the next level (if available). Please be advised that the guidelines and timeframes for subsequent levels of appeal may be included in the decision letter provided by the payer. If this information is not readily available, contact the payer's appeals department for further instructions.

Appendix A. Sample CMS-1500 Claim Form for Bilateral OCT

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA — PICA — CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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 — SEX M F

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

5. PATIENT'S ADDRESS (No., Street): 123 MAIN ST

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

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

CITY: ANYTOWN — STATE: CA

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (123) 555-1234

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

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

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: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Rel...

1. 377. 30

2. — 4.

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

Enter the appropriate ICD-9-CM diagnosis code that describes the patient's condition that necessitates the procedure *(Example shown)*

Unit count of 1 (for unilateral or bilateral imaging)

	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	04	01	11						92133		377. 30		1		NPI	
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

CPT code for OCT of the optic nerve (Use 92134 for OCT of retina)

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. BALANCE DUE $

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

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