PRACTITIONER'S STATEMENT

This form has been prepared to assist you in the completion of your insurance claim form and contains all the information that the practitioner is required to provide. Fill out the personal information requested on your insurance company claim form and attach this statement to it. Each patient, not the insurance company, is responsible for payment to this office.

Patient _____ **GROUP #** _____ AGE _____ S/S# _____

Address _____ **CLAIM #** _____

☐ Illness (first symptom) or ☐ Injury (accident)

Date first consulted you for this condition / /

Date patient able to return to work / /

Dates ☐ Total disability from / / through / /

☐ Partial disability

Has patient ever had same or similar symptoms? Yes ☐ No ☐

Phone _____

Place of Service: ☐ Office ☐ Home ☐ Other _____

☐ New Case ☐ Continued Claim

(Diagnosis if not checked below) _____

5th digit required

	DATE	DATE	DATE	DATE
NEW PATIENT (Office Visit)				
☐ 99201 Self Limited or Minor	$	$	$	$
☐ 99203 Moderate Severity	$	$	$	$
☐ 99204 Moderate to High Severity	$	$	$	$
ESTABLISHED PATIENT (Office Visit)				
☐ 99211 Minimal	$	$	$	$
☐ 99212 Self Limited or Minor	$	$	$	$
☐ 99213 Low to Moderate Severity	$	$	$	$
☐ 99214 Moderate to High Severity	$	$	$	$
ACUPUNCTURE PROCEDURES				
☐ 97035 Ultrasound, ea. 15 min.	$	$	$	$
☐ 97110 Therapeutic Proc., ea. 15 min.				
☐ 97112 Neuromuscular Reeducation	$	$	$	$
☐ 97124 Massage Therapy				
☐ 97139 Unlisted Therapeutic Proc. Specify_____	$	$	$	$
☐ 97140 Manual Therapy Techniques (Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.	$	$	$	$
☐ 97799 Unlisted Phys. Med. Serv. Specify_____	$	$	$	$
☐ 97802 Medical Nutrition, Indiv., Init.	$	$	$	$
☐ 97803 Medical Nutrition, Indiv., Subseq.	$	$	$	$
☐ 97810 One or more Needles without Elec. Stim. Initial 15 minutes	$	$	$	$
☐ 97811 Each additional 15 minutes without Elec. Stim.	$	$	$	$
☐ 97813 One or more Needles with Elec. Stim. Initial 15 minutes				
☐ 97814 Each Additional 15 minutes with Elec. Stim.	$	$	$	$
☐ _____ _____	$	$	$	$
MODALITIES				
☐ 97010 Hot/Cold Treatment	$	$	$	$
☐ 97012 Traction, Mechanical	$	$	$	$
☐ 97039 Unlisted Modality Specify_____	$	$	$	$
MISCELLANEOUS				
☐ 99056 Home Services	$	$	$	$
☐ 99070 Supplies/Materials (Not included in office visit)	$	$	$	$
☐ Herbs ☐ Needles ☐ Supplements	$	$	$	$
☐ 99080 Special Reports (UCR)	$	$	$	$
☐ _____ _____	$	$	$	$
TOTAL EACH DATE OF SERVICE	$	$	$	$

☐ Abdominal Pain*	789.0__
☐ Amenorrhea	626.0
☐ Alcohol Dependence*	303.9__
☐ Allergies	995.3
☐ Asthma*	493.9__
☐ Backache, Unspecified	724.5
☐ Bell's Palsy	351.0
☐ Bronchitis	490.0
☐ Carpal Tunnel Syndrome	354.0
☐ Colitis/Gastroenteritis NOS	558.9
☐ Common Cold	460
☐ Constipation*	564.0__
☐ Cough	786.2
☐ Cystitis, Acute	595.0
☐ Dermatitis/Eczema	692.9
☐ Dietary Surveillance and Counseling	V65.3
☐ Drug Dependence*	304.9__
☐ Dysmenorrhea	625.3
☐ Edema	782.3
☐ Fatigue/Malaise*	780.7__
☐ Gastric Pain	787.3
☐ Hay Fever/Rhinitis Unspecified	477.9
☐ Headache (Tension)	307.81
☐ Headache (Common Migraine)*	346.1__
☐ Headache (Pain in Head NOS)	784.0
☐ Hypertension	401.9
☐ Hypotension	458.0
☐ Indigestion	536.8
☐ Infertility, Female - Unspecified Origin	628.9
☐ Infertility, Male - Unspecified	606.9
☐ Insomnia	780.52
☐ Menorrhagia	626.2
☐ Myalgia-Myositis, Unspecified	729.1
☐ Nausea*	787.0__
☐ Neuritis/Neuralgia	729.2
☐ Obesity*	278.0__
☐ Osteoarthrosis*	715.9__
☐ Osteoporosis*	733.0__
☐ Otitis Media, Unspecified	382.9
☐ Premenstrual Syndrome	625.4
☐ Prostatitis, Acute	601.0
☐ Respiratory Infection	487.1
☐ Respiratory Abnormalities*	786.0__
☐ Rheumatoid Arthritis	714.0
☐ Sinusitis (Acute)	461.9
☐ Sinusitis (Chronic)	473.9
☐ Sore Throat (Acute)	462
☐ Sore Throat (Chronic)	472.1
☐ Stiffness of Joints*	719.5__
☐ Symptomatic Menopausal or Female Climacteric States	627.2
☐ Tendinitis NOS	726.90
☐ Tinnitus*	388.3__
☐ TMJ	524.60
☐ Tobacco Dependence	305.1
☐ Vertigo NOS	780.4
☐ Vitamin Deficiency Unspecified	269.2
JOINT PAIN - ARTHRALGIA	
☐ Site Unspecified	719.40
☐ Shoulder	719.41
☐ Upper Arm	719.42
☐ Forearm	719.43
☐ Hand	719.44
☐ Pelvic/Thigh	719.45
☐ Lower Leg	719.46
☐ Ankle/Foot	719.47
☐ Cervicalgia	723.1
☐ Brachial Neuritis/Radiculitis NOS	723.4
☐ Thoracic Spine Pain	724.1
☐ Lumbago/Lumbalgia	724.2
☐ Sciatica	724.3
☐ Bursitis/Shoulder	726.10
☐ Bursitis/Elbow	726.33
☐ Bursitis/Knee	726.60

TOTAL THIS BILLING $ _____

Old Balance $ _____

TOTAL $ _____

Payment Received $ _____

New Balance $ _____

NEXT APPOINTMENT:

DATE _____ TIME _____

_____
PROVIDER'S NAME TYPED DEGREE

S.S.# or I.R.S.# _____

LIC. # _____

Phone # _____

Address _____

_____

_____
Providers Signature

White - Office Copy Yellow - Insurance Copy Pink - Patient's Copy

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