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 _____ Age _____ S/S# _____

Address _____

_____

Phone _____

Today's Date: / /

☐ 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 ☐

Place of Service: ☐ Office ☐ Home ☐ Other _____

☐ New Case
☐ Continued Claim

DIAGNOSIS (if not checked below): _____

NEW PATIENT (Office Visit) — Fee

- ☐ 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 Med. Nutrition, Indiv., Init. _____
- ☐ 97803 Med. 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 _____

Old Balance $ _____

Today's Charges $ _____

TOTAL $ _____

Payment Received $ _____

New Balance $ _____

GENERAL

5th digit required

- ☐ 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 Abnormalities* 786.0__
- ☐ Respiratory Infection 487.1
- ☐ 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

SPRAIN/STRAIN

- ☐ Shoulder/Upper Arm 840.9
- ☐ Elbow/Forearm 841.9
- ☐ Wrist* 842.0__
- ☐ Hip/Thigh 843.9
- ☐ Hand 842.10
- ☐ Knee/Leg 844.9
- ☐ Ankle/Foot* 845.0__
- ☐ Neck 847.0
- ☐ Thoracic 847.1
- ☐ Lumbar 847.2
- ☐ Sacrococcygeal 847.3
- ☐ Coccyx 847.4

NEXT APPOINTMENT:

DATE _____ TIME _____

PROVIDER'S NAME TYPED DEGREE

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

LIC. # _____

Phone # _____

Address _____

_____

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed

Provider's Signature

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