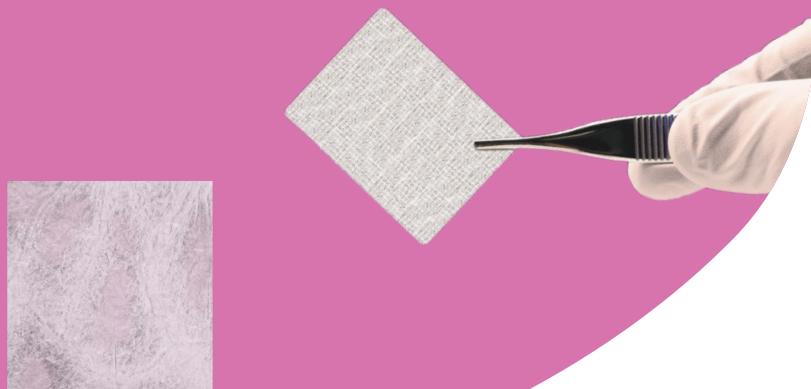




Smith+Nephew CAMPs Portfolio Reimbursement Guide 2026

Physician Office and
Traveling Physician Group



GRAFIX PL PRIME[◊]
Lyopreserved
Placental Membrane

GRAFIX PRIME[◊]
Cryopreserved
Placental Membrane

GRAFIX CORE[◊]
Cryopreserved
Placental Membrane

GRAFIX PLUS[◊]
Lyopreserved
Placental Membrane

OASIS[®]
Wound Matrix

OASIS[®]
Burn Matrix

OASIS[®] ULTRA
Tri-Layer Matrix

Reimbursement Hotline Services

Phone: 866-988-3491

Fax: 866-304-6692

Additional fax: 443-472-4274

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.

Medical necessity checklist

It is recommended that the provider review clinical evidence for GRAFIX® and OASIS® for indications of use, clinical outcomes, and frequency of applications. Providers should review applicable Medicare LCD or medical policy for GRAFIX and OASIS and ensure all requirements and coverage guidelines are met.

Suggested documentation: The following should be documented in the patient's medical record based on current wound care standards:

- Duration of wound (# of days or weeks)
- Prior conservative treatments that have failed to induce significant wound healing
- Wound diagnosis (e.g. DFU, VLU, etc.); ICD 10 codes should report etiology and wound location
- Wound is free of infection and osteomyelitis (noted at each visit)
- Adequate treatment of the underlying disease(s) contributing to the non-healing wound
 - Documented diabetes management plan, appropriate offloading or compression if applicable
- Describe wound dressings applied and frequency of wound dressing changes
- Adequate blood flow / perfusion; documentation of tests used to assess perfusion
- Patient's nutritional status is adequate for healing
- 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
- If patient is a smoker, document patient was counselled that smoking inhibits wound healing, and resources for smoking cessation were provided
- Measurement of the wound progression at each visit (length x width x depth) Including at least twice in the last 30 days and before the first treatment (be specific about modalities such as debridement, advanced dressings, collagen, etc.)
- Wound appearance at each visit: amount of granulation tissue, amount and description of exudate and slough, appearance of wound edge
- Was appropriate wound preparation performed (e.g. debridement)? If not, explain why? If yes, describe level of debridement and tissue removed at each visit
- Record skin substitute application number and improvement since last treatment at each visit
- Document skin substitute product, size used, lot #, expiration date, amount applied, and amount discarded, if any.

1. Type of Insurance Verification Requested: Prior Authorization support will be initiated if required by Payer, include clinical documentation to support PA							
New Wound	Subsequent Applications	Re-Verification	New Insurance	I opt out of Prior Authorization support services			
Single Wound	Multiple Wounds	Procedure 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:	Phone #:	Gender: Female Male					
3. Insurance Information: Please attach a copy (front & back) of patient's insurance card(s)							
Cardholder Name:	DOB:	Relationship to patient:					
Primary Payer:	SSN:	Plan Type:					
Policy #:	Group #:	Card Phone #:					
Secondary Payer:	Plan Type:						
Policy #:	Group #:	Card Phone #:					
4. Healthcare Provider (HCP) & Facility/Agency Information: Please note, we do not verify inpatient benefits. Provider must confirm Place of Service (POS). Select only ONE POS.							
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: _____			
Skilled Nursing Facility:	Provider is responsible for confirming skilled/unskilled status. Is the patient expected to be in a skilled bed on the date of service? Yes No						
HCP First Name:	HCP Last Name:			M.I.:			
HCP NPI:	HCP Tax ID#:	HCP PTAN:					
Specialty: MD DO DPM PA NP/FNP Other: _____							
Contact Name:	Phone #:						
Facility Name:	Facility NPI:	Facility PTAN/Facility CCN:					
Facility Address:	Facility Tax ID:						
City, State, Zip:	Phone #:	Fax #:					
5. Treatment Information: If needed, select up to 3 products in order of preference numerically							
<input type="checkbox"/> GRAFIX® PL PRIME Membrane (Q4133)		<input type="checkbox"/> GRAFIX® PRIME Membrane (Q4133)		<input type="checkbox"/> GRAFIX® CORE Membrane (Q4132)		<input type="checkbox"/> GRAFIX® PLUS Membrane (Q4304)	
<input type="checkbox"/> OASIS® Wound Matrix (Q4102)		<input type="checkbox"/> OASIS® Burn Matrix (Q4103)		<input type="checkbox"/> OASIS® ULTRA Tri-Layer Matrix (Q4124)			
CPT: Legs/Arms/Trunk < 100 sq cm: _____ 15271/15272		Legs/Arms/Trunk > 100 sq cm: _____ 15273/15274		Feet/Hands/Head < 100 sq cm: _____ 15275/15276		Feet/Hands/Head > 100 sq cm: _____ 15277/15278	
NOTE: Prior use of skin substitutes or global periods related to the same wound may impact reimbursement							
PRP: Chronic Diabetic PRP Procedure (CENTRIO): _____ G0465							
6. Wound Information & Diagnosis Code(s): Please include ICD-10 codes that indicate Primary diagnosis, ulcer type, AND location. MUST include the full alpha-numeric ICD-10 Code. Ex: E11.621; L97.512; If treating more than one wound, please provide diagnosis codes for each additional wound							
ICD-10 Codes: #1 Wound (Required)			ICD-10 Codes: #2 Wound				
Primary (Etiology): _____			Primary (Etiology): _____				
Secondary (Ulcer/Location): _____			Secondary (Ulcer/Location): _____				
Tertiary (Optional): _____			Tertiary (Optional): _____				
Wound Dimensions: L _____ W _____ D _____			Wound Dimensions: L _____ W _____ D _____				
7. Prior Authorization: For PA support please attach all clinical notes related to the wound treatment episode							
# of Anticipated Applications/Visits _____ Anticipated Units _____							
8. Authorized 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 Smith+Nephew 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.							
If prior authorization is required, I authorize Smith and Nephew to initiate the authorization.							
For typed or stamped signatures below: I agree that this typed or stamped signature has the same validity and meaning as my handwritten signature.							
Authorized 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 CAMPs/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, acellular and matrix-like products (CAMPs) 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®, Q4304 for GRAFIX PLUS® and OASIS® Wound Matrix Q4102, OASIS® Burn Q4103 and OASIS® Tri-layer Q4124.**

CPT codes	Coding	Physician office (Non-facility***)	Physician facility (HOPD)
		Medicare national average payment	Medicare national average 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	\$157.99	\$75.15
+15272	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	\$25.72	\$14.70
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	\$321.98	\$171.68
+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)	\$86.84	\$39.08
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	\$160.32	\$84.17
+15276	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	\$33.73	\$22.04
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	\$361.40	\$197.40
+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)	\$101.20	\$48.77

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.

*** **Commercial Payer Payment Rates** It is commonly understood that the payment rates of a commercial payer for the application of skin substitutes (CPTs 15271-15278) and Cellular Tissue Product (CTP) used in the procedure (HCPCS code) are confidentially negotiated between the commercial payer and providers. During such negotiations, the commercial payer may use different methodologies to establish payment rates, such as Medicare Physician Fee Schedule (MPFS), payment based on a set percentage of charges, or bundled payment, where the CPT fee includes the Cellular Tissue Product. Providers participating in Value-Based Pricing agreements may also be paid on a per member per month basis. Additionally, those different rate determining methodologies vary greatly among commercial payers. Therefore, to confirm payment rates, please consult your office practice manager or billing manager. If you are unable to identify your practice's contracted rates, please reach out to the specific payer's Provider Relations Representative.

Reference: The Centers for Medicare and Medicaid Services, CY 2026 Physician Fee Schedule Final Rule, Addendum B, Retrieved from <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f>

Product HCPCS codes and modifiers

GRAFIX® and OASIS® Matrix HCPCS codes, UPC codes and billing units:

All GRAFIX Membranes and OASIS Matrix are billed per square centimeter. One billable unit is 1 cm². 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 OASIS Matrix and the maximum billable units per product size.

For CY 2026 CMS is considering skin substitute products as incident-to supplies when they are used as part of a covered application procedure paid under the PFS in the non-facility setting. For CY 2026 CMS has set a single payment rate of **\$127.14** per sq. cm.

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
	GRAFIX PLUS® 2 x 3 cm (6 cm ²)	PS16023	859857003562	6	Q4304
	GRAFIX PLUS 3 x 4 cm (12 cm ²)	PS16034	859857003555	12	Q4304
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
Dehydrated and stored at 15-30°C until use.	GRAFIX CORE 5 x 5 cm (25 cm ²)	PS12055	859857003128	25	Q4132
	OASIS® Wound Matrix 3 x 3.5 cm (11 cm ²)	8213-1000-33	10827002466224	11	Q4102
	OASIS Wound Matrix 3 x 7 cm (21 cm ²)	8213-1000-37	10827002466262	21	Q4102
	OASIS® Burn Matrix 3 x 3.5 cm (11 cm ²)	RQ: 8213-3000-16	10827002576046	11	Q4103
	OASIS Burn Matrix 3 x 7 cm (21 cm ²)	RQ: 8213-3000-18	10827002576060	21	Q4103
	OASIS Burn Matrix 5 x 7 cm (35 cm ²)	RQ: 8213-3000-13	10827002576039	35	Q4103
	OASIS Burn Matrix 7 x 10 cm (70 cm ²)	RQ: 8213-3000-09	10827002576015	70	Q4103
	OASIS Burn Matrix 7 x 20 cm (140 cm ²)	RQ: 8213-3000-11	10827002576022	140	Q4103
	OASIS® ULTRA Tri-Layer Matrix 3 x 3.5 cm (11 cm ²)	8213-0000-16	10827002352428	11	Q4124
	OASIS ULTRA Tri-Layer Matrix 3 x 7 cm (21 cm ²)	8213-0000-18	10827002352442	21	Q4124
	OASIS ULTRA Tri-Layer Matrix 5 x 7 cm (35 cm ²)	8213-0000-13	10827002231198	35	Q4124
	OASIS ULTRA Tri-Layer Matrix 7 x 10 cm (70 cm ²)	8213-0000-09	10827002564630	70	Q4124
	OASIS ULTRA Tri-Layer Matrix 7 x 20 cm (140 cm ²)	8213-0000-11	10827002564654	140	Q4124

Important notes:

1. **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:

Product	MUE (Units)
GRAFIX CORE® (Q4132)	50
GRAFIX PL PRIME® and GRAFIX PRIME® (Q4133)	113
GRAFIX PLUS® (Q4304)	Not set
OASIS® Wound Matrix (Q4102)	21
OASIS® Burn Matrix (Q4103)	Not set
OASIS® ULTRA Tri-Layer Matrix (Q4124)	140

Note: MUE data as of 2019.

2. **Billing of Incident-to Supply**

In the CY 2026 Physician Fee Schedule (PFS) final rule CMS finalized to pay skin substitutes as incident-to supplies beginning January 1, 2026. As a result, non-BLA skin substitutes are no longer payable under Medicare Part B as a drug or biological as of January 1, 2026, and only the administered portion is payable.

3. **Consolidated Billing — Medicare Only — Skilled Nursing Facility**

If a CAMP is applied and billed when the Medicare patient is under a Skilled Episode of Care, separate reimbursement will not be received.

- Medicare covers up to 100 days of care in a Skilled Nursing Facility (SNF), in a single benefit period, if the patient continues to be eligible.
- Under consolidated billing, a SNF must submit all Medicare claims for services provided to residents except for specifically excluded services. Consolidated billing rules make the SNF responsible for such services when rendered outside of the SNF.
- Reimbursement for services provided to patients in a Skilled Nursing Facility (SNF) are included in a bundled payment from the Part A Medicare Administrative Contractor (MAC) directly to the SNF
- Physician services may include both a professional and technical component. The technical component is subject to consolidated billing and should be billed to and reimbursed by the SNF.
- The SNF furnishes the services, either directly or under an “arrangement/contract” with an outside facility. The SNF bills Medicare for all services provided. The outside facility requests payment from the SNF, not Medicare Part B.

Reference: The Centers for Medicare and Medicaid Services, CY 2026 Hospital Outpatient PPS Final Rule
 Retrieved from <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulationsnotices/ cms-1809-fc.pdf>
 Retrieved from <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf>

ICD-10 Diagnosis Code guidelines for wound care

GRAFIX PL[®] Membrane, GRAFIX[®] Membrane and OASIS[®] Matrix coverage is based on medical necessity and subject to payer coverage guidelines. For most payers, GRAFIX PL Membrane, GRAFIX Membrane and OASIS Matrix 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	Description
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.



Sample Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/> <input type="checkbox"/>												CARRIER <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA		BLK LUNG		OTHER		1a. INSURED'S I.D. NUMBER		(For Program in Item 1)					
<input type="checkbox"/> (Medicare#)		<input type="checkbox"/> (Medicaid#)		<input type="checkbox"/> (ID#/DoD#)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE						SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
						MM	DD	YY	M <input type="checkbox"/>		F <input type="checkbox"/>												
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED						7. INSURED'S ADDRESS (No., Street)											
						Self <input type="checkbox"/>		Spouse <input type="checkbox"/>		Child <input type="checkbox"/>		Other <input type="checkbox"/>											
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. EMPLOYMENT? (Current or Previous)			<input type="checkbox"/> YES <input type="checkbox"/> NO														
						b. AUTO ACCIDENT?			<input type="checkbox"/> YES <input type="checkbox"/> NO			PLACE (State)			a. INSURED'S DATE OF BIRTH			SEX					
						c. OTHER ACCIDENT?			<input type="checkbox"/> YES <input type="checkbox"/> NO						MM DD YY			M <input type="checkbox"/> F <input type="checkbox"/>					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)						b. OTHER CLAIM ID (Designated by NUCC)											
												c. INSURANCE PLAN NAME OR PROGRAM NAME											
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
												<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>											
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 _____											
14. GRAFT, WOUND, OR INJURY (GWI), OR PREGNANCY (LMP)						15. OTHER DATE						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
						QUAL	MM	DD	YY	FROM	MM	DD	YY	TO	MM	DD	YY						
17. MEDICAL RECORD NUMBER OR OTHER SOURCE						17a.						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
						17b. NPI						FROM	MM	DD	YY	TO	MM	DD	YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																							
GRAFIX PL PRIME (5 x 5) per sq cm																							
20. OUTSIDE LAB? \$ CHARGES																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re						22. RESUBMISSION						ORIGINAL REF. NO.											
A. E11.621						B. L97.522						C. CPT/HCPCS											
E. _____						F. _____						G. EPDS Family Plan											
I. _____						J. _____						H. ID. #											
K. _____						L. _____						J. RENDERING PROVIDER ID. #											
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. DIAGNOSIS		G. DAYS OR UNITS		H. EPDS Family Plan		I. ID. #		J. RENDERING PROVIDER ID. #	
From MM DD YY						To MM DD YY								\$ CHARGES									
1 01 01 19 01 01 26 11						15275						A, B				1							
2 01 01 19 01 01 26 11						Q4133						A, B				25		NPI					
3																							
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)		28. TOTAL CHARGE		\$		29. AMOUNT PAID		30. Rsvd. for NUCC Use			
										<input type="checkbox"/> YES <input type="checkbox"/> NO				\$		\$							
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.)																							
32. SERVICE FACILITY LOCATION INFORMATION																							
33. BILLING PROVIDER INFO & PH# ()																							
SIGNED _____						DATE _____						a. NPI		b.		a. NPI		b.					