Smith+Nephew

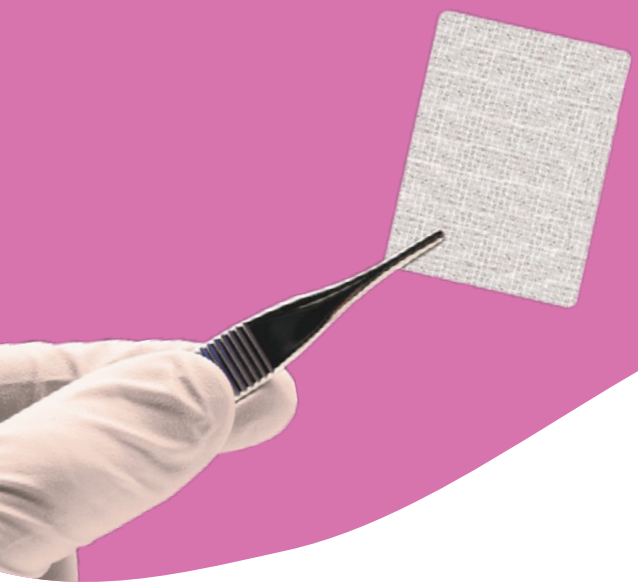
GRAFIX PL PRIME◊
Lyropreserved
Placental Membrane

GRAFIX PRIME◊
Cryopreserved
Placental Membrane

GRAFIX CORE◊
Cryopreserved
Placental Membrane

GRAFIX PLUS◊
Lyropreserved
Placental Membrane

Reimbursement guide **2025**
Physician Office



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◊ for indications of use, clinical outcomes, and frequency of applications. Providers should review applicable Medicare LCD or medical policy for GRAFIX 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 # and expiration date, amount discarded, if any.

Smith+Nephew

Smith+Nephew Reimbursement Hotline Services
GRAFIX® Membrane and OASIS® Matrix
Insurance Verification Request (IVR) Form
Phone: 866-988-3491 Fax: 866-304-6692

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** ☐ **IVR Lite** ☐ **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#:	

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: If needed, select up to 3 products in order of preference numerically

____ GRAFIX® PL PRIME Membrane (Q4133) ____ GRAFIX® PRIME Membrane (Q4133) ____ GRAFIX® CORE Membrane (Q4132) ____ GRAFIX® PLUS Membrane (Q4304)

____ 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 same wound may impact reimbursement

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)
Primary (Etiology): _____
Secondary (Ulcer/Location): _____
Tertiary (Optional): _____
Wound Dimensions: L_____W_____D_____

ICD-10 Codes: #2 Wound
Primary (Etiology): _____
Secondary (Ulcer/Location): _____
Tertiary (Optional): _____
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 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.
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.

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

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

MSFE15-41896-0524

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◊** and **Q4304 for GRAFIX PLUS◊**

Coding		Physician office (Non-facility***)	Physician facility (HOPD)
CPT codes	**Code description**	**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	$148.47	$81.51
+15272	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	$23.61	$16.17
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	$295.00	$187.29
+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)	$76.98	$42.37
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	$153.97	$90.57
+15276	Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	$31.70	$23.94
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	$329.93	$215.75
+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)	$91.22	$54.02

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 2025 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◊ 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, CAMPs/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 PARM 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
	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
	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:

   - Product name
   - NDC code
   - WAC of product
   - WAC per sq. cm.
   - 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:

   - Product name
   - Product size (in sq. cm.)
   - Product number
   - Invoice price per piece
   - 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: c. GRAFIX PLUS◊ (Q4304) is not set.

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, Q4133.

   a. Common Modifiers:

   i. JC – Skin substitute used as a graft
   ii. KX – Provider deems continued care medically necessary
   iii. JW – Discarded skin substitute, not used (wastage)
   iv. JZ – Zero discarded skin substitute, no 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.

Smith+Nephew

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

Smith+Nephew

Sample Claim Form

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Service Description

Primary and Secondary ICD-10 Codes

Product & Procedure Charges

CPT Code

HCPCS Code

Billing Units

Date of Service

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Clear Form