J. SKLAR COMPUTERS, inc.
(516) 791-5630

P.O. BOX 340
VALLEY STREAM, N.Y. 11582

MEDI-CAL BILLING CLAIM FORM

PROVIDER ACCT or NPI:___________________ **INSURANCE COMPANY TO BILL:** *____________________*

PROVIDER'S NAME :____________________________

PATIENT INFO: (Please Print)

LAST NAME, FIRST ____________________, ____________________

PATIENT I.D. NUMBER [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

BIRTH DATE [ ][ ][ ][ ][ ][ ]

SEX: M F STUDENT?: Y N RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD

INSURED NAME + DOB (* ONLY If Different *) ____________________________________

ZIP CODE [ ][ ][ ][ ][ ]

REFERRING INFORMATION AND AUTHORIZATIONS (If applicable)

PRIOR AUTHORIZATION NUMBER: ________________________________ **ARE YOU ACCEPTING ASSIGNMENT :** Y / N

DATE OF SERVICE: ______/______/______

DIAGNOSIS CODES: (Circle ***One*** Dx and put *NUMBER* IN BLANK-for which eye, ***if*** indicated)
RT-1 / LT-2 / OU-3

Code	Diagnosis	Code	Diagnosis	Code	Diagnosis
H10.45	ALLERGY	**E11.9**	**DIABETES w/oc. signs**	G51.4	MyoKymia
Z961	**APHAKIA (PSEUDOPHAKIA)**	E11.319	DIABETIC W/O Mac Edema	H47.21 __	Optic Atrophy
H57.1 __	ASTHENOPIA	E11.311	DIABETIC W/ Mac Edema	**H53.14 __**	**PHOTO PHOBIA**
H01.029	Blepharitis	H53.2	DIPLOPIA	H11.15 __	Pinguecula
H53.8	**BLURRING OF VISION**	**H04.123**	**DRY EYE** (OU)	H11.05 __	Pterygium
H25.81__	**CATARACT/senile**	H04.21__	EPIPHORIA/Lacrimation	H02.41 __	Ptosis
H00.11	Chalazion rt. upper	**H40.05__**	**GLAUCOMA (OC. H.T.N.)**	**H35.44 __**	**Retinal Degen/Age related**
H11.3 __	**CONJUNCTIVAL Hemorrhage**	H40.11__1	GLAUC OPEN ANGLE - **Mild**	H35.72 __	Retinal Detachment
H10.1 __	**CONJUNCTIVITIS Acute**	H40.11__2	GLAUC OPEN ANGLE - **Moderate**	H35.6 __	Retinal Hemorrhage
H10.45	CONJUNCTIVITIS **Allergic**	**G43.b0**	**HEADACHES / Migraine**	H02052	Trichiasis
S05.0_XA	CORNEAL Abrasion initial	**H35.03__**	**HYPERTENS. w/ OC. SIGNS**	**H53.45 __**	**Visual Field Defect**
H18.22__	CORNEAL Edema	H20.2 __	Iritis	**H43.39 __**	**Vitreous Floaters**
T15.0__XA	CORNEAL Foreign Body	**H35.31**	**Macular DEGEN Sen./dry**	H43.81 __	Vitreous Detachment
		H35.32	Macular Degen Sen./wet		
		H35.36__	Macular Drusen		

Other Dx. Code: ________ ____________________

PUT MORE SPECIFIC CODES IF NEEDED: ________ ____________________

EXAMINATIONS CODES:(Circle Code)

	NEW PT	ESTAB.PT	FEE
-f2	___ 92004	___ 92014 COMPREHENSIVE	________
-f1	___ 92002	___ 92012 INTERMEDIATE	________
-f3	___ 99211	Follow/Up EXAM	________
af3	___ 99202	___ 99212 EXAM / EXPANDED	________
cf3	___ 99203	___ 99213 EXAM / DETAILED	________
af4	___ 99204	___ 99214 EXAM / COMPREH.	________
-g	___ 92133	GDX *(Optic Nerve Scan)*	________
ag	___ 92134	GDX *(Post. Retina Scan)*	________
	___ 68761-E2	Punctal Plug - **E2** Rgt L Lid	________
	___ 68761-E4	Punctal Plug - **E4** Lft L Lid	________

	Code	Description	FEE
-f4 __	92202	OPHTH. Extended	________
-p __	92250	FUNDUS PHOTO	________
-f7 __	92020	GONIOSCOPY	________
-e __	92285	EXTERNAL PHOTO	________
f8 __	92081	FIELD LIMITED	________
-f8 __	92082	FIELD INTERMED	________
-af8 __	92083	FIELD COMPREH.	________
-y __	76514	Pachymetry	________
__	67820	Epilate Eyelash	________
__	68040	Meibomian Expression R/L	________
-r __	92015	Refraction (Non-covered svc.)	________

Misc. Procedures:

DATE	PROCEDURE	MODIFIER	TIMES	DIAGNOSIS	CHARGES

AUTHORIZATION TO FILE CLAIM:

I Certify that I qualify for benefits to cover my medical services at this office. In the event of a problem with my insurance company.
I aree to reimburse this office within 14 days of notice from either my carrier or this office for any co-payments, deductibles or denials that follow from submission of this claim.
I am aware of the HIPPA Privacy rules and I authorize release of any records necessary to process this claim. I request payment of benefits for services rendered to the party who accepts assignment. I give authorization for release to or from CMA or my Insurance carrier and its agents information needed to determine these benefits payable for services.

PATIENT SIGNATURE: X________________________________

DR. MUST RETAIN COPY 6 YEARS