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

1096 STRATHMORE STREET
N. WOODMERE, N.Y. 11581

MEDI-CAL BILLING CLAIM FORM

PROVIDER NUMBER:_____ **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 STREET ADDRESS (* NOT CITY *) _____ ZIP CODE | | | | | |

INSURED NAME (If Different) _____ Group Number (If Applies) _____

REFERRING INFORMATION AND AUTHORIZATIONS (If applicable)

PRIOR AUTHORIZATION NUMBER: _____ NAME OF REFERRING PHYSICIAN: _____

Referring Physician I.D. or N. P. I. _____ ARE YOU ACCEPTING ASSIGNMENT : Y / N

DIAGNOSIS CODES: (Circle *One*)

373.32 ALLERGY
V43.1 APHAKIA (PSEUDOPHAKIA)
379.22 Asteroid Hyalitis
379.91 ASTHENOPIA
373.02 Blepharitis
368.8 BLURRING OF VISION
366.16 CATARACT/senile
373.2 Chalazion
372.72 Conjunctiv. Hemorrhage
372.05 CONJUNCTIVITIS Acute
372.14 CONJUNCTIVITIS Allergic
918.1 CORNEAL Abrasion
371.24 CORNEAL Edema
930.0 CORNEAL Foreign Body

250.50 DIABETES w/oc. signs
362.04 DIABETIC w/backgrnd sign
368.2 DIPLOPIA
375.15 DRY EYE
375.21 EPIPHORIA,LACRIMATION
365.01 GLAUCOMA (Borderline)
365.11 GLAUCOMA OPEN ANGLE
365.22 GLAUCOMA ACUTE CLOSE.
346.91 HEADACHES / Migraine etc.
362.11 HYPERTENS. w/ OC. SIGNS
364.23 Iritis
362.51 MACULAR DEGEN Sen./dry
362.52 Macular Degen Sen./wet
362.57 Macular Drusen

377.15 Optic Atrophy
368.13 PHOTO PHOBIA
372.51 Pinguecula
372.42 Pterygium
374.33 Ptosis
362.64 Retinal Degen/unspec
362.42 Retinal Detachment
362.81 Retinal Hemorrhage
362.74 Retinitis Pigmentosa
364.03 Uveitis
368.44 Visual Field Defect
379.24 VITREOUS FLOATERS
Other Dx. Code:
_____ _____

DATE OF SERVICE: ____/____/____

EXAMINATIONS CODES:(Circle Code)

	NEW PT	ESTAB.PT		FEE
-f2	92004	92014	COMPREHENSIVE	_____
-f1	92002	92012	INTERMEDIATE	_____

Office E/M Codes:

-f3	99211		Follow/Up EXAM	_____
af3	99202	99212	EXAM / EXPANDED	_____
cf3	99203	99213	EXAM / DETAILED	_____
af4	99204	99214	EXAM / COMPREH.	_____

			FEE
-f4	92225	92226 (1or2) OPHTH. Extend.	_____
-p	92250	FUNDUS PHOTO	_____
-f7	92020	GONIOSCOPY	_____
f8	92081	FIELD LIMITED	_____
-f8	92082	FIELD INTERMED	_____
-af8	____	92083 FIELD COMPREH.	_____
-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 co., I agree 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

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