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

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

MEDICARE CLAIM FORM

ACCOUNT NUMBER :_____ **N.Y. / N.J.**

PROVIDER'S NAME :_____ CIRCLE ONE: **BC/BS-MC / GHI-MC / APHAKIC RX**

PATIENT LAST NAME, FIRST, M.I. *** Exactly as on M.C. card *** BIRTH DATE SEX ADDRESS

_____, _____ ___/___/___ **M F** _____

CITY, STATE, ZIP MEDICARE #

_____ _____ - - -

***IF* PRESCRIBING or RENDERING DOCTOR IS *NOT* YOUR REGISTERED DOCTOR:**
DR.'s Name:_____ **Dr.'s NPI:** |__|__|__|__|__|__|__|__|__|__|

DIAGNOSIS CODES: (Circle *One*)

373.32 ALLERGY
V43.1 APHAKIA (PSEUDOPHAKIA)
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
370.62 CORNEAL Neovasc / Panus

250.50 DIABETES w/oc. signs
362.04 DIABETIC w/backgrnd sign
368.2 DIPLOPIA
375.15 DRY EYE
375.21 EPIPHORIA,LACRIMATION
365.04 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
370.62 Retinal Nevus
368.44 Visual Field Defect
379.24 Vitreous Floaters
379.21 Vitreous Detachment
Other Dx. Code:
_____ _____

DATE OF SERVICE: ___/___/___

EXAMINATIONS CODES: (Circle Code)

NEW PT	ESTAB.PT		FEE				FEE
-f1	920**02**	920**12** INTERMEDIATE		-f7	92020	GONIOSCOPY	
-f2	920**04**	920**14** COMPREHENSIVE		f8	92081	FIELD LIMITED	
-f3	99201	99211 BRIEF OFFICE VISIT		-f8	92082	FIELD INTERMED	
-f4	92225	92226 OPHTHAL. *(1 or 2)*		af8	92083	FIELD COMP.	
-f	92250	FUNDUS PHOTO		-p	76514	PACHYMETRY	
-g	92133	GDX *(Post. Retina Scan)*		-r	92015	**Refraction** (Non-covered svc.)	

PQRS CODES: (Circle if appropriate:) **Diabetes: 2022F / Glaucoma: 2027F / Macula: 2019F / Not-Dilated: 1P**

Nursing Home Facility (if appropriate): Name: _____ NPI_____

FOR POST-OP GLASSES ONLY:

PSEUDOPHAKIC LENSES: (New Pseudophakes only are payable * ENTER # OF LENSES 1 OR 2)

f3	V2100	PL-4.00 SPH. **SINGL VISION**		af3	V2200	PL - 4.00 **BIFOCAL**	
f4	V2101	4.25 - 7.00 SPHERE		af4	V2201	4.25 - 7.00	
f5	V2103	PLAN - 4 = PL - 2.00 CYL.		af5	V2203	PL - 4 = PL - 2.00 CYL.	
f6	V2104	PLAN - 4 = 2.25-4.00 CYL.		af6	V2204	PL - 4 = 2.25 - 4.00 CYL.	
-A	V2107	4.25 - 7 = PL - 2.00 CYL.		^A	V2207	4.25 - 7 = PL - 2.00 CYL.	
	V2523	CONTACT LENS		^P	V2781	**Progressive Lens** (Non-covered)	
f7	V2755	**ULTRA VIOLET**		f9	V2020	**FRAME**	
af7	V2745	**TINT PLASTIC**		af9	V2025	**Deluxe Frame** (addl. Non-covered fee)	
	OTHER: _____				OTHER: _____		

FEES SUMMARY:

TOTAL AMOUNT BILLED: $_____.____

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 request that payment of Medicare/Blue Cross benefits be made on my behalf to this office for services rendered to or for me (eye exams, home visits, eye glasses). I give authorization for release to or from the H.C.F.A. and its agents information needed to determine these benefits payable for services.

PATIENT SIGNATURE: _____

DR. MUST RETAIN COPY 6 YEARS

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