ATTENDING DOCTOR'S STATEMENT (Charge Slip)

THIS "CHARGE SLIP" HAS BEEN ESPECIALLY PREPARED TO ASSIST YOU IN THE COMPLETION OF YOUR INSURANCE CLAIM FORM AND CONTAINS ALL THE INFORMATION THE INSURANCE CARRIER REQUESTS OF THE DOCTOR.

HOW TO PREPARE YOUR HEALTH INSURANCE CLAIM: CONTACT YOUR INSURANCE COMPANY REPRESENTATIVE OR MEDICAL PLAN CARRIER FOR A CLAIM FORM. FILL IN YOUR PART OF THEIR FORM (USUALLY PART 1 OR PART A). ATTACH THE YELLOW COPY OF THIS "CHARGE SLIP" TO IT AND TURN IT IN OR MAIL IT TO THE INSURANCE COMPANY OR HEALTH PLAN OFFICE ACCORDING TO THEIR INSTRUCTIONS. IF YOU MUST SUBMIT MORE THAN ONE CLAIM FORM BECAUSE OF ADDITIONAL COVERAGE, USE A PHOTOCOPY OF THE PINK PORTION OF YOUR "CHARGE SLIP."

PATIENT'S NAME: _____ SEX ☐ M ☐ F BIRTHDATE _____
FIRST MIDDLE LAST MO. DAY YEAR

INSURED FILL OUT THIS SECTION: CLAIM IS FOR ☐ SELF ☐ SPOUSE ☐ CHILD NAME _____
INSURED'S NAME _____ CLAIM # _____ GROUP # _____ I.D. # _____
INSURED'S ADDRESS _____ INSURED'S BIRTHDATE _____

☐ NEW CASE
☐ CONTINUED

DISABILITY RELATED TO: ☐ ACCIDENT ☐ PREGNANCY ☐ OTHER _____
DATE FIRST CONSULTED YOU FOR THIS CONDITION _____ HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
DATE PATIENT ABLE TO RETURN TO WORK? _____ ☐ PARTIAL ☐ TOTAL DISABILITY FROM _____ THRU _____

CODE	SERVICE	FEE	TOTAL
NEW PATIENT (Office Visit)			
☐ 99201	Self Limited or Minor		
☐ 99202	Low to Moderate Severity		
☐ 99203	Moderate Severity		
☐ 99204	Moderate to High Severity		
☐ 99205	Moderate to High Severity		
ESTABLISHED PATIENT (Office Visit)			
☐ 99211	Minimal		
☐ 99212	Self Limited or Minor		
☐ 99213	Low to Moderate Severity		
☐ 99214	Moderate to High Severity		
☐ 99215	Moderate to High Severity		
PROCEDURES			
☐ 97032	Elec. Stim. (Manual) ea. 15 min.		
☐ 97035	Ultrasound, ea. 15 min.		
☐ 97110	Therapeutic Proc., ea. 15 min.		
☐ 97112	Neuromuscular Reeducation		
☐ 97124	Massage		
☐ 97139	Unlisted Therapeutic Proc. Specify_____		
☐ 97140	Manual Therapy Techniques (Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.		
☐ 98940	Manipulation, 1-2 regions		
☐ 98941	Manipulation, 3-4 regions		
☐ 98942	Manipulation, 5 regions		
☐ 98943	Extraspinal, 1 or more regions		
MODALITIES			
☐ 97010	Hot/Cold Treatment		
☐ 97012	Traction, Mechanical		
☐ 97014	Electrical Stimulation (Unatt.)		
☐ 97039	Unlisted Modality Specify_____		

CODE	SERVICE	FEE	TOTAL
MISCELLANEOUS			
☐ 99070	Supplies/Supports		
☐ 99070	Supplements		
☐ 99080	Special Reports (UCR)		
☐ 99080	Review of Medical Records		
☐			
☐			
X-RAY DIAGNOSTIC STUDIES			
☐ 72040	Cervical Spine/2-3v		
☐ 72050	Cervical Spine complete		
☐ 72052	Cervical (inc. flex. & ext. views)		
☐ 72070	Thoracic Spine/2v		
☐ 72072	Thoracic Spine/3v		
☐ 72090	Scoliosis study complete		
☐ 72100	Lumbosacral/2-3v		
☐ 72110	Lumbosacral/4v		
☐ 72114	Lumbosacral, complete (including bending views)		
☐ 72190	Pelvis, complete		
☐ 72202	Sacro-iliac joints		
☐ 73030	Shoulder, complete		
☐ 73070	Elbow/2v		
☐ 73100	Wrist/2v		
☐ 73120	Hand/2v		
☐ 73500	Hip, unilateral/1v		
☐ 73560	Knee/1-2v		
☐ 73600	Ankle/2v		
☐ 73620	Foot/2v		
☐			
		TOTAL	

DIAGNOSIS _____

DOCTOR'S NAME (typed) _____

I.D. # _____ PHONE # _____

ADDRESS _____

_____
Doctor's Signature

_____
Date

DATES OF SERVICES

MO.	DATE	YEAR

☐ RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE DOCTOR WHOSE NAME APPEARS ABOVE TO FURNISH MY INSURANCE COMPANY ALL INFORMATION WHICH THE INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY.

☐ ASSIGNMENT OF INSURANCE: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE DOCTOR OF BENEFITS DUE ME FOR THE ABOVE SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT.

SIGNATURE PATIENT/INSURED (OR PARENT IF MINOR) _____ DATE _____

White - Office Copy Yellow - Insurance Copy Pink - Patient's Copy #1027 MISSION PRINTING (559) 227-7640 (800) 693-2108