PATIENT: Fill out the personal information requested on your insurance co. claim form and attach this statement to it. This statement contains all the information the doctor is required to supply.

ATTENDING PRACTITIONER'S STATEMENT
(CHARGE SLIP AND RECEIPT)

INSURANCE CARRIER: This statement has been adopted to keep paperwork down. Any additional form or itemized bills will be forwarded upon a receipt of $_____

Patient's Name: _____ Date of Service: _____ Place of service ☐ Office ☐ Hospital ☐ Home

NEW PATIENT (Office Visit)	Fee
☐ 99201 Self Limited or Minor	
☐ 99203 Moderate Severity	
☐ 99204 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	
ACUPUNCTURE PROCEDURES	
☐ 97035 Ultrasound, ea. 15 min.	
☐ 97110 Therapeutic Proc., ea. 15 min.	
☐ 97112 Neuromuscular Reeducation	
☐ 97124 Massage Therapy	
☐ 97139 Unlisted Therapeutic Proc. Specify_____	
☐ 97140 Manual Therapy Techniques (Manipulation, Myofascial Release, Manual Traction, Mobilization) 1 or more regions, ea. 15 min.	
☐ 97799 Unlisted Phys. Med. Serv. Specify_____	
☐ 97802 Med. Nutrition, Indiv., Init.	
☐ 97803 Med. Nutrition, Indiv., Subseq.	
☐ 97810 One or more Needles without Elec. Stim. Initial 15 minutes	
☐ 97811 Each additional 15 minutes without Elec. Stim.	
☐ 97813 One or more Needles with Elec. Stim. Initial 15 minutes	

	Fee
☐ 97814 Each Additional 15 minutes with Elec. Stim.	
☐ _____ _____	
☐ _____ _____	
MODALITIES	
☐ 97010 Hot/Cold Treatment	
☐ 97012 Traction, Mechanical	
☐ 97039 Unlisted Modality Specify_____	
MISCELLANEOUS	
☐ 99056 Home Services	
☐ 99070 Supplies/Materials (Not included in office visit)	
☐ Herbs ☐ Needles ☐ Supplements	
☐ 99080 Special Reports (UCR)	
☐ _____ _____	
☐ _____ _____	
TOTAL	
Old Balance	$_____
Today's Charges	$_____
TOTAL	$_____
Payment Received	$_____
New Balance	$_____

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information requested to process this claim.

Signed:

ASSIGNMENT OF BENEFITS: I authorize payment to be made directly to the below named healthcare provider. I understand I am responsible for charges not covered by this assignment.

Signed:

Date first consulted:
Mo. _____ Day _____ Year _____

☐ New Case ☐ Continued Claim

☐ Total Disability ☐ Partial Disability

☐ Related to: _____

Disability from _____ to _____

Date to return to work_____

_____
PROVIDER'S NAME TYPED DEGREE

S.S.# or I.R.S.# _____

LIC. # _____ Phone # _____

Address_____

_____

_____
Provider's Signature

ICD-9-CM CODES (Diagnosis if not checked below) DIAGNOSIS _____

***5th digit required**

☐ 789.0__	Abdominal Pain*	☐ 692.9	Dermatitis/Eczema	☐ 715.9__	Osteoarthrosis*	☐ 719.42	Upper Arm
☐ 626.0	Amenorrhea	☐ 304.9__	Drug Dependence*	☐ 625.4	Premenstrual Syndrome	☐ 719.43	Forearm
☐ 303.9__	Alcohol Dependence*	☐ 625.3	Dysmenorrhea	☐ 569.42	Rectal Pain	☐ 719.44	Hand
☐ 493.9__	Asthma*	☐ 782.3	Edema	☐ 487.1	Respiratory Infection	☐ 719.45	Pelvic Region/Thigh
☐ 351.0	Bell's Palsy	☐ 780.7__	Fatigue/Malaise*	☐ 714.0	Rheumatoid Arthritis	☐ 719.46	Lower Leg
☐ 490.0	Bronchitis	☐ 787.3	Gastric Pain	☐ 473.9	Sinusitis (chronic)	☐ 719.47	Ankle/Foot
☐ 727.3	Bursitis	☐ 307.81	Headache (tension)	☐ 627.2	Symptomatic Menopausal or	☐ 723.1	Cervicalgia
☐ 354.0	Carpal Tunnel Syndrome	☐ 346.1__	Headache (common migraine)*		Female Climacteric States	☐ 723.4	Cervical Radiculitis
☐ 786.59	Chest Pain	☐ 401.9	Hypertension	☐ 726.90	Tendinitis NOS	☐ 724.1	Thoracic Spine Pain
☐ 558.9	Colitis/Gastroenteritis NOS	☐ 536.8	Indigestion	☐ 388.3__	Tinnitus*	☐ 724.4	Thoracic/Lumbar Radiculitis
☐ 564.0__	Constipation*	☐ 780.52	Insomnia	☐ 524.60	TMJ	☐ 724.2	Lumbago/Lumbalgia
☐ 733.6	Costochondritis	☐ 626.2	Menorrhagia	☐ 780.4	Vertigo NOS	☐ 724.3	Sciatica
☐ 595.0	Cystitis, Acute	☐ 787.0__	Nausea*		**JOINT PAIN**	☐ 724.6	Disorders of Sacrum
		☐ 729.2	Neuritis/Neuralgia	☐ 719.41	Shoulder Region	☐ 724.79	Coccygodynia

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