Case Study - Sleep Apnea

- Patient's Chief Complaint: Patient complains of fatigue, headaches and dry mouth when wakening in the morning. Partner also complains of snoring. Patient had sleep study on 01/05/13, results were negative. (Attach copy of Sleep Study and be unsuccessful with CPAP)
- Assessment: Patient needs an appliance for sleep apnea.
- Plan: Advised patient in order to correct condition he will need a sleep apnea appliance.
- Procedures to be performed (CPT):

Dental code D5999-Unspecified maxillofacial prosthesis, by report

CPT code: E0486-Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustments.

DME: Durable Medical Equipment-make sure to put lab fee on claim form in box 20-$165.00

- Diagnosis/ICD-10 Codes:

G47.30- Sleep Apnea Unspecified

G47.33-Obstructive sleep apnea

D37.02- Neoplasm of Uncertain Behavior of Tongue

G47.39-Other organic sleep apnea

Modifier NU for Sleep Apnea Appliance

Box 32-Name of Lab:

- Best Lab,1234 San Diego Avenue, San Diego, CA 92000
- TIN-1234567891

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

D5999 unspecified maxillofacial prosthesis, by report

Medical Code(s)

21083	Impression and custom preparation; palatal lift prosthesis
21089	Unlisted maxillofacial prosthetic procedure
21100	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
42281	Insertion of pin-retained palatal prosthesis
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment

ICD-10-CM Diagnostic Codes

C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
C05.2	Malignant neoplasm of uvula
C05.9	Malignant neoplasm of palate, unspecified
C06*	Malignant neoplasm of other and unspecified parts of mouth
C41.0	Malignant neoplasm of bones of skull and face
D00.0*	Carcinoma in situ of lip, oral cavity and pharynx
D10.30	Benign neoplasm of unspecified part of mouth
D10.39	Benign neoplasm of other parts of mouth
D37.01	Neoplasm of uncertain behavior of lip
D37.02	Neoplasm of uncertain behavior of tongue
D37.04	Neoplasm of uncertain behavior of the minor salivary glands
D37.05	Neoplasm of uncertain behavior of pharynx
G47.30	Sleep apnea, unspecified
G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.39	Other sleep apnea
M27.8	Other specified diseases of jaws
S02.40*	Fracture of malar, maxillary and zygoma bones, unspecified
S02.41*	LeFort fracture
S02.42*	Fracture of alveolus of maxilla

Medical Code	P50	P75	P90	RVU	MEDICARE	GFP
21083	3801	4675	6148	45.93	1642.21	90
21089	IR	IR	IR	-	-	YYY
21100	670	1004	1403	33.16	1185.63	90
21110	1461	1721	2454	23.35	834.87	90
42281	486	606	732	5.93	212.03	10
E0485	-	-	-	-	-	-
E0486	-	-	-	-	-	-

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Aetna
PO Box 981107

El Paso TX 79998-1109

PICA

CARRIER

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 445231234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT, Willard P

3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1967 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): PATIENT, Willard P

5. PATIENT'S ADDRESS (No., Street): 1234 Happy Way

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1234 Happy Way

CITY: San Diego STATE: CA

8. RESERVED FOR NUCC USE

CITY: San Diego STATE: CA

ZIP CODE: 92111 TELEPHONE (Include Area Code): (858) 1234567

ZIP CODE: 92111 TELEPHONE (Include Area Code): (858) 1234567

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 00613890

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1967 SEX M [X] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [X]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Petco

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SOF DATE 10 01 2015

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 01 2016 QUAL. 431

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK Default L Proivider

17a.

17b. NPI 5123699478

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) PWK13AA PWKDBAA

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES: 16500

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. G47 30 B. G47 33 C. D37 02 D. G47 39

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 01 2015	10 01 2015	11		E0486	NU	ABCD	3800 00	1		NPI	5123699478
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN: 52286418 [ ] [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3800 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Default L Proivider

SOF 10 01 2015

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Best Lab
1234 San Diego Avenue
San Diego CA 92000

a. 1234567891 b.

33. BILLING PROVIDER INFO & PH # (858) 7894567

Default L Proivider
5126 S Welcome Way
San Diego CA 92111

a. 5123699478 b.

Case Study TMJ

- Patient's Chief Complaint: Patient has been experiencing constant pain in the jaw joint, along with popping upon opening mouth, in addition to frequent headaches.
- Assessment: Patient needs an occlusal orthotic device.
- Plan: Patient has been advised to correct condition he will need an occlusal orthotic device with follow up appointments for adjustments.
- Procedures to be performed (CPT):

Dental code D7880-Occlusal Orthotic Device

CPT code-S8262 Mandibular Orthopedic repositioning device

DME-Durable Medical Equipment-Make sure to put lab fee on claim form in box #20.

- Diagnosis/ICD-10 codes:

M26.62-TMD Arthralgia

M26.69-TMJ sounds upon opening

R51-Head and/or facial pain

G44.1-Vascular headache not elsewhere classified

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Aetna
PO Box 981107

El Paso TX 79998-1109

CARRIER

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 445231234

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENT, Willard P	10 14 1967 M [X] F [ ]	PATIENT, Willard P
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1234 Happy Way	Self [X] Spouse [ ] Child [ ] Other [ ]	1234 Happy Way
CITY: San Diego / STATE: CA	8. RESERVED FOR NUCC USE	CITY: San Diego / STATE: CA
ZIP CODE: 92111 / TELEPHONE (Include Area Code): (858) 1234567		ZIP CODE: 92111 / TELEPHONE (Include Area Code): (858) 1234567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 00613890
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [ ] NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX: 10 14 1967 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [ ] NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Petco
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SOF DATE: 10 01 2015

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DK Default L Proivider	17a. / 17b. NPI 5123699478	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 01 2015 / 10 01 2015								NPI	5123699478
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
152286418	[X]		[ ] YES [ ] NO	$	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (858) 7894567
Default L Proivider SOF SIGNED 10 01 2015 DATE	a. / b.	Default L Proivider 5126 S Welcome Way San Diego CA 92111 a. 5123699478 / b.

6

C05.2	Malignant neoplasm of uvula
C05.8	Malignant neoplasm of overlapping sites of palate
C05.9	Malignant neoplasm of palate, unspecified
C06.0	Malignant neoplasm of cheek mucosa
C06.1	Malignant neoplasm of vestibule of mouth
C06.2	Malignant neoplasm of retromolar area
C06.80	Malignant neoplasm of overlapping sites of unspecified parts of mouth
C06.89	Malignant neoplasm of overlapping sites of other parts of mouth
C06.9	Malignant neoplasm of mouth, unspecified
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil
C09.9	Malignant neoplasm of tonsil, unspecified
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D00.02	Carcinoma in situ of buccal mucosa
D00.03	Carcinoma in situ of gingiva and edentulous alveolar ridge
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
D00.06	Carcinoma in situ of floor of mouth
D00.07	Carcinoma in situ of tongue
D00.08	Carcinoma in situ of pharynx
D10.1	Benign neoplasm of tongue
D10.2	Benign neoplasm of floor of mouth
D10.30	Benign neoplasm of unspecified part of mouth
D10.39	Benign neoplasm of other parts of mouth
D10.4	Benign neoplasm of tonsil
D11*	Benign neoplasm of major salivary glands
D37.01	Neoplasm of uncertain behavior of lip
D37.02	Neoplasm of uncertain behavior of tongue
D37.03*	Neoplasm of uncertain behavior of the major salivary glands
D37.04	Neoplasm of uncertain behavior of the minor salivary glands
G44.1	Vascular headache, not elsewhere classified
K04.8	Radicular cyst
K09.0	Developmental odontogenic cysts
K09.1	Developmental (nonodontogenic) cysts of oral region
K09.8	Other cysts of oral region, not elsewhere classified
K09.9	Cyst of oral region, unspecified
M26.00	Unspecified anomaly of jaw size
M26.01	Maxillary hyperplasia
M26.02	Maxillary hypoplasia
M26.03	Mandibular hyperplasia
M26.04	Mandibular hypoplasia
M26.05	Macrogenia
M26.06	Microgenia
M26.10	Unspecified anomaly of jaw-cranial base relationship
M26.11	Maxillary asymmetry
M26.12	Other jaw asymmetry
M26.19	Other specified anomalies of jaw-cranial base relationship
M26.4	Malocclusion, unspecified
M26.60	Temporomandibular joint disorder, unspecified
M26.61	Adhesions and ankylosis of temporomandibular joint
M26.62	Arthralgia of temporomandibular joint
M26.63	Articular disc disorder of temporomandibular joint
M26.69	Other specified disorders of temporomandibular joint
M26.9	Dentofacial anomaly, unspecified
M27.2	Inflammatory conditions of jaws
M27.4*	Other and unspecified cysts of jaw
M27.5*	Periradicular pathology associated with previous endodontic treatment
M27.6*	Endosseous dental implant failure
M27.8	Other specified diseases of jaws
M27.9	Disease of jaws, unspecified
M62.40	Contracture of muscle, unspecified site
M62.838	Other muscle spasm
Q67.0	Congenital facial asymmetry
Q67.4	Other congenital deformities of skull, face and jaw
R13.11	Dysphagia, oral phase
R13.12	Dysphagia, oropharyngeal phase
R51	Headache
R63.3	Feeding difficulties
R93.0	Abnormal findings on diagnostic imaging of skull and head, not elsewhere classified
S01.40*	Unspecified open wound of cheek and temporomandibular area
S01.42*	Laceration with foreign body of cheek and temporomandibular area
S01.50*	Unspecified open wound of lip and oral cavity
S01.51*	Laceration of lip and oral cavity without foreign body
S01.52*	Laceration of lip and oral cavity with foreign body
S02.2*	Fracture of nasal bones
S02.3*	Fracture of orbital floor
S02.4*	Fracture of malar, maxillary and zygoma bones
S02.5*	Fracture of tooth (traumatic)
S02.6*	Fracture of mandible
S02.8*	Fractures of other specified skull and facial bones
S02.9*	Fracture of unspecified skull and facial bones
S03*	Dislocation and sprain of joints and ligaments of head
S07*	Crushing injury of head

Medical Code	P50	P75	P90	RVU	MEDICARE	GFP
21085	1464	1827	2642	22.08	789.46	10
21089	IR	IR	IR	-	-	YYY
21110	1461	1721	2454	23.35	834.87	90
21499	IR	IR	IR	-	-	YYY
41899	IR	IR	IR	-	-	YYY
99070	25	50	100	-	-	XXX
S8262	-	-	-	-	-	-

* ICD-10 Code requires additional digit(s). See Appendix B.

D7880 occlusal orthotic device, by report

Medical Code(s)

21085	Impression and custom preparation; oral surgical splint
21089	Unlisted maxillofacial prosthetic procedure
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21499	Unlisted musculoskeletal procedure, head
41899	Unlisted procedure, dentoalveolar structures
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
S8262	Mandibular orthopedic repositioning device, each

ICD-10-CM Diagnostic Codes

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Aetna
PO Box 981107

El Paso TX 79998-1109

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[ ] (Medicare#) [ ] (Medicaid#) [ ] (ID#/DoD#) [ ] (Member ID#) [ ] (ID#) [ ] (ID#) [X] OTHER (ID#)	445231234
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT, Willard P	3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1967 SEX: M [X] F [ ]
4. INSURED'S NAME (Last Name, First Name, Middle Initial) PATIENT, Willard P	
5. PATIENT'S ADDRESS (No. Street) 1234 Happy Way	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
7. INSURED'S ADDRESS (No., Street) 1234 Happy Way	
CITY: San Diego — STATE: CA	8. RESERVED FOR NUCC USE
CITY: San Diego — STATE: CA	
ZIP CODE: 92111 — TELEPHONE (Include Area Code): (858) 1234567	
ZIP CODE: 92111 — TELEPHONE (Include Area Code): (858) 1234567	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER 00613890	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO
a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1967 SEX: M [X] F [ ]	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO
c. INSURANCE PLAN NAME OR PROGRAM NAME Petco	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SOF DATE 10 01 2015

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SOF

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 09 01 2016 QUAL. 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Default L Proivider	17a. 17b. NPI 5123699478	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) PWK06AA PWKPOAA		20. OUTSIDE LAB? [X] YES [ ] NO $ CHARGES 13500
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M26 62 B. M26 69 C. R51 D. G44 1 E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 01 2015	10 01 2015	11		S8262	25	ABCD	950 00	1		NPI	5123699478
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
152286418	[ ]	[X]		[X] YES [ ] NO	$ 950 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Default L Proivider
SOF SIGNED 10 01 2015 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Best Lab
1234 San Diego Avenue
San Diego CA 92000
a. 1234567891 b.

33. BILLING PROVIDER INFO & PH # (858) 7894567
Default L Proivider
5126 S Welcome Way
San Diego CA 92111
a. 5123699478 b.

9

Case Study-CT Scan/Abnormal Findings

CDT-D0395-CPT Procedure Code-76376-3D rendering with interpretation and reporting of image

CDT-D0380-CPT Procedure Code-70486-computed image, without contrast material

ICD-10 Codes-R93.0 Abnormal findings on diagnostic imaging of skull

G50.1 Vascular Headache

K12.2 Cellulitis & abscess of the mouth

Box 22-Original Reference Number- 43256

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Aetna
PO Box 981107

El Paso TX 79998-1109

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 445231234
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT, Willard P	3. PATIENT'S BIRTH DATE MM DD YY: 10 14 1967 SEX M [X] F [ ]		4. INSURED'S NAME (Last Name, First Name, Middle Initial): PATIENT, Willard P
5. PATIENT'S ADDRESS (No., Street): 1234 Happy Way	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street): 1234 Happy Way
CITY: San Diego STATE: CA	8. RESERVED FOR NUCC USE		CITY: San Diego STATE: CA
ZIP CODE: 92111 TELEPHONE (Include Area Code): (858) 1234567			ZIP CODE: 92111 TELEPHONE (Include Area Code): (858) 1234567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER: 00613890
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]		a. INSURED'S DATE OF BIRTH MM DD YY: 10 14 1967 SEX M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [ ]		c. INSURANCE PLAN NAME OR PROGRAM NAME: Petco
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED SOF DATE 10 01 2015

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14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: OK Default L Proivider	17a. 17b. NPI 5123699478	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10 01 2015	10 01 2015									NPI	5123699478
										NPI	
										NPI	
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
52286418 [X]					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (858) 7894567
efault L Proivider		Default L Proivider 5126 S Welcome Way San Diego CA 92111
OF 10 01 2015 GNED DATE	a. b.	a. 5123699478 b.

K08.494 Partial loss of teeth due to other specified cause, class IV
K08.499 Partial loss of teeth due to other specified cause, unspecified class
K08.5* Unsatisfactory restoration of tooth
K08.50 Unsatisfactory restoration of tooth, unspecified
K08.51 Open restoration margins of tooth
K08.52 Unrepairable overhanging of dental restorative materials
K08.53 Fractured dental restorative material
K08.530 Fractured dental restorative material without loss of material
K08.531 Fractured dental restorative material with loss of material
K08.539 Fractured dental restorative material, unspecified
K08.54 Contour of existing restoration of tooth biologically incompatible with oral health
K08.55 Allergy to existing dental restorative material
K08.56 Poor aesthetic of existing restoration of tooth
K08.59 Other unsatisfactory restoration of tooth
K09* Cysts of oral region, not elsewhere classified
K09.0 Developmental odontogenic cysts
K09.1 Developmental (nonodontogenic) cysts of oral region
K09.8 Other cysts of oral region, not elsewhere classified
K09.9 Cyst of oral region, unspecified
K11* Diseases of salivary glands
K11.0 Atrophy of salivary gland
K11.1 Hypertrophy of salivary gland
K11.2 Sialoadenitis
K11.20 Sialoadenitis, unspecified
K11.21 Acute sialoadenitis
K11.22 Acute recurrent sialoadenitis
K11.23 Chronic sialoadenitis
K11.3 Abscess of salivary gland
K11.4 Fistula of salivary gland
K11.5 Sialolithiasis
K11.6 Mucocele of salivary gland
K11.7 Disturbances of salivary secretion
K11.8 Other diseases of salivary glands
K11.9 Disease of salivary gland, unspecified
K11.2* Sialoadenitis
K11.20 Sialoadenitis, unspecified
K11.21 Acute sialoadenitis
K11.22 Acute recurrent sialoadenitis
K11.23 Chronic sialoadenitis
K11.20* Sialoadenitis, unspecified
K12* Stomatitis and related lesions
K12.0 Recurrent oral aphthae
K12.1 Other forms of stomatitis
K12.2 Cellulitis and abscess of mouth
K12.3 Oral mucositis (ulcerative)
K12.30 Oral mucositis (ulcerative), unspecified
K12.31 Oral mucositis (ulcerative) due to antineoplastic therapy
K12.32 Oral mucositis (ulcerative) due to other drugs
K12.33 Oral mucositis (ulcerative) due to radiation
K12.39 Other oral mucositis (ulcerative)
K13* Other diseases of lip and oral mucosa
K13.0 Diseases of lips
K13.1 Cheek and lip biting
K13.2 Leukoplakia and other disturbances of oral epithelium, including tongue
K13.21 Leukoplakia of oral mucosa, including tongue
K13.22 Minimal keratinized residual ridge mucosa
K13.23 Excessive keratinized residual ridge mucosa
K13.24 Leukokeratosis nicotina palati
K13.3 Hairy leukoplakia
K13.4 Granuloma and granuloma-like lesions of oral mucosa
K13.5 Oral submucous fibrosis
K13.6 Irritative hyperplasia of oral mucosa
K13.7 Other and unspecified lesions of oral mucosa
K13.70 Unspecified lesions of oral mucosa
K13.79 Other lesions of oral mucosa
K13.2* Leukoplakia and other disturbances of oral epithelium, including tongue
K13.21 Leukoplakia of oral mucosa, including tongue
K13.22 Minimal keratinized residual ridge mucosa
K13.23 Excessive keratinized residual ridge mucosa
K13.24 Leukokeratosis nicotina palati
K13.29 Other disturbances of oral epithelium, including tongue
K13.7* Other and unspecified lesions of oral mucosa
K13.70 Unspecified lesions of oral mucosa
K13.79 Other lesions of oral mucosa
K14* Diseases of tongue
K14.0 Glossitis
K14.1 Geographic tongue
K14.2 Median rhomboid glossitis
K14.3 Hypertrophy of tongue papillae
K14.4 Atrophy of tongue papillae
K14.5 Plicated tongue
K14.6 Glossodynia
K14.8 Other diseases of tongue
K14.9 Disease of tongue, unspecified
L12* Pemphigoid
L12.0 Bullous pemphigoid
L12.1 Cicatricial pemphigoid
L12.2 Chronic bullous disease of childhood
L12.3 Acquired epidermolysis bullosa
L12.30 Acquired epidermolysis bullosa, unspecified
L12.31 Epidermolysis bullosa due to drug
L12.35 Other acquired epidermolysis bullosa
L12.8 Other pemphigoid
L12.9 Pemphigoid, unspecified
M26.0* Major anomalies of jaw size
M26.00 Unspecified anomaly of jaw size
M26.01 Maxillary hyperplasia
M26.02 Maxillary hypoplasia
M26.03 Mandibular hyperplasia
M26.04 Mandibular hypoplasia
M26.05 Macrogenia
M26.06 Microgenia
M26.07 Excessive tuberosity of jaw
M26.09 Other specified anomalies of jaw size
M26.1* Anomalies of jaw-cranial base relationship
M26.10 Unspecified anomaly of jaw-cranial base relationship
M26.11 Maxillary asymmetry
M26.12 Other jaw asymmetry
M26.19 Other specified anomalies of jaw-cranial base relationship
M26.2* Anomalies of dental arch relationship
M26.20 Unspecified anomaly of dental arch relationship
M26.21 Malocclusion, Angle's class
M26.211 Malocclusion, Angle's class I
M26.212 Malocclusion, Angle's class II
M26.213 Malocclusion, Angle's class III
M26.219 Malocclusion, Angle's class, unspecified
M26.22 Open occlusal relationship
M26.220 Open anterior occlusal relationship
M26.221 Open posterior occlusal relationship
M26.23 Excessive horizontal overlap
M26.24 Reverse articulation
M26.25 Anomalies of interarch distance

D0393 **treatment simulation using 3D image volume**

D0394 **digital subtraction of two or more images or image volumes of the same modality**

D0395 **fusion of two or more 3D image volumes of one or more modalities**

Medical Code(s)

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent works

D0380 **cone beam CT image capture with limited field of view - less than one whole jaw**

D0381 **cone beam CT image capture with field of view of one full dental arch - mandible**

D0382 **cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium**

D0383 **cone beam CT image capture with field of view of both jaws; with or without cranium**

D0384 **cone beam CT image capture for TMJ series including two or more exposures**

Medical Code(s)

70486 Computed tomography, maxillofacial area; without contrast material

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent works

76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstati

76380 Computed tomography, limited or localized follow-up study

ICD-10-CM Diagnostic Codes

G44.1	Vascular headache, not elsewhere classified
K08.9	Disorder of teeth and supporting structures, unspecified
K11.0	Atrophy of salivary gland
K11.1	Hypertrophy of salivary gland
K11.2*	Sialoadenitis
K11.3	Abscess of salivary gland
K11.4	Fistula of salivary gland
K11.5	Sialolithiasis
K11.6	Mucocele of salivary gland
K11.7	Disturbances of salivary secretion
K11.8	Other diseases of salivary glands
K11.9	Disease of salivary gland, unspecified
M27.0	Developmental disorders of jaws
M27.2	Inflammatory conditions of jaws
M27.49	Other cysts of jaw
M27.8	Other specified diseases of jaws
M27.9	Disease of jaws, unspecified
R06.5	Mouth breathing
R06.89	Other abnormalities of breathing
R13.0	Aphagia
R13.1*	Dysphagia
R19.6	Halitosis
R51	Headache
R93.0	Abnormal findings on diagnostic imaging of skull and head, not elsewhere classified
S02.2*	Fracture of nasal bones

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

Aetna
PO Box 981107

El Paso TX 79998-1109

PICA

CARRIER

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CITY San Diego STATE CA	8. RESERVED FOR NUCC USE	CITY San Diego STATE CA
ZIP CODE 92111 TELEPHONE (Include Area Code) (858) 1234567		ZIP CODE 92111 TELEPHONE (Include Area Code) (858) 1234567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 00613890
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX 10 14 1967 M [X] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) [ ] YES [X] NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME Petco
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED SOF

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK Default L Proivider	17a. 17b. NPI 5123699478	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. R93 0 B. G50 1 C. K12 2 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 7879876 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05 23 2016	05 23 2016	11		70486		ABC	450 00	1		NPI	5123699478
05 23 2016	05 23 2016	11		76376		ABC	234 00	1		NPI	5123699478
05 23 2016	05 23 2016	11		99203	25	ABC	189 00	1		NPI	5123699478
										NPI	
										NPI	
										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
52286418 [ ] [X]		[X] YES [ ] NO	$ 873 00	$	

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Default L Proivider SOF SIGNED 05 23 2016 DATE	a. b.	Default L Proivider 5126 S Welcome Way San Diego CA 92111 a. 5123699478 b.

PHYSICIAN OR SUPPLIER INFORMATION

14