

Patient's Name _____

Patient's Number _____ Date of Service _____

ATTENDING DOCTOR'S STATEMENT/INSURANCE REPORT

OFFICE MEDICAL EXAM	CPT	FEE
(1) Eye Exam Int. / NP	92002	_____
(2) Eye Exam Comp. / NP	92004	_____
(3) Eye Exam Int. / EP	92012	_____
(4) Eye Exam Comp. / EP	92014	_____
(5) Refraction	92015	_____
<i>(Severity of Problem(s) / Level of Medical Decision Making)</i>		
(6) Minor / Straightfwd. / NP	99201	_____
(7) Low to Mod. / Straightfwd. / NP	99202	_____
(8) Mod. / Low Complex. / NP	99203	_____
(9) Mod. to High / Mod. Complex. / NP	99204	_____
(10) Mod. to High / High Complex. / NP	99205	_____
(11) Minimal Evaluation / EP	99211	_____
(12) Minor / Straightfwd. / EP	99212	_____
(13) Low to Mod. / Low Complex. / EP	99213	_____
(14) Mod. to High / Mod. Complex. / EP	99214	_____
(15) Mod. to High / High Complex. / EP	99215	_____
CONSULTATION (REF. BY: _____)		
<i>(Severity of Problem(s) / Level of Medical Decision Making)</i>		
(16) Minor / Straightfwd.	99241	_____
(17) Low / Straightfwd.	99242	_____
(18) Mod. / Low Complex.	99243	_____
(19) Mod. to High / Mod. Complex.	99244	_____
(20) Mod. to High / High Complex.	99245	_____
CO-MANAGEMENT (RT/LT)		
(21) Laser Surgery (i.e. YAG)	66821-55	_____
(22) Extra. Cat. Rem. w/IOL, Complex	66982-55	_____
(23) Intra. Cat. Extraction w/ IOL	66983-55	_____
(24) Extra. Cat. Removal w/ IOL	66984-55	_____
(25) Presbyopia IOL	V2788	_____
VISION THERAPY		
(26) Sensorimotor Exam	92060	_____
(27) Orthoptic and/or Pleoptic Training	92065	_____
(28) Developmental Testing, Limited	96110	_____
THERAPEUTICS (RT/LT/50) (E1/E2/E3/E4)		
(29) F.B. Removal, Conjunctival Superficial	65205	_____
(30) F.B. Removal, Conjunctival Embedded	65210	_____
(31) F.B. Removal, Corneal w/ Slit Lamp	65222	_____
(32) Epilation by Forceps Only	67820	_____
(33) F.B. Removal, Eyelid Embedded	67938	_____
(34) Closure of Lacrim. Punct. by Plug, Ea.	68761	_____
(35) Dilat. of Lacrim. Punct. w/ or w/o Irrig.	68801	_____
SPECIAL DIAGNOSTIC TESTING (RT/LT/50) (52)		
<i>(Requires Interpretation and Report)</i>		
(36) Computerized Corneal Topography (Uni or Bi.)	92025	_____
(37) Gonioscopy (Separate Procedure)	92020	_____
(38) Ext. Ophthalmoscopy, Initial (Per Eye)	92225	_____
(39) Ext. Ophthalmoscopy, Subs. (Per Eye)	92226	_____
(40) Corneal Pachymetry (Uni. or Bi.)	76514	_____
(41) RPS Adeno Detector	87809	_____
(42) Visual Field, Limited Exam	92081	_____
(43) Visual Field, Intermediate Exam	92082	_____
(44) Visual Field, Extended Exam	92083	_____
(45) Serial Tonometry	92100	_____
(46) Scanning Laser / SCODI (Per Eye)	92135	_____
(47) Fundus Photography	92250	_____
(48) External Ocular Photography	92285	_____
S CODES		
(49) Complicated CL Eval.	S0592	_____
(50) Routine Exam w/ Refraction / NP	S0620	_____
(51) Routine Exam w/ Refraction / EP	S0621	_____
(52) Corneal Topography, Unilateral	S0820	_____

OPHTHALMIC MATERIALS/SUPPLIES	Pair 1	Pair 2
(53) Frame, Basic	V2020	_____
(54) Frame, Deluxe	V2025	_____
(55) Single Vision RT	V21	_____
(56) Single Vision LT	V21	_____
(57) Bifocal RT	V22	_____
(58) Bifocal LT	V22	_____
(59) Trifocal RT	V23	_____
(60) Trifocal LT	V23	_____
(61) Progressive RT	V27	_____
(62) Progressive LT	V27	_____
(63) Progressive-Overage RT	V2781	_____
(64) Progressive-Overage LT	V2781	_____
(65) Anti-Reflective Coating	V2750	_____
(66) Balance Lens	V2700	_____
(67) Occluder Lens	V2770	_____
(68) Oversize Lens	V2780	_____
(69) Prism	V2715	_____
(70) Slab-Off Prism	V2710	_____
(71) Scratch Resistant Coating	V2760	_____
(72) Tint Any Color, Solid, Grad. or Equal	V2745	_____
(73) Tint, Photochromatic	V2744	_____
(74) UV Lens	V2755	_____
(75) Low Vision Aid / Hand Held	V2600	_____
(76) Low Vision Aid, Single Lens	V2610	_____
(77) Telescopic / Compound Lens Sys.	V2615	_____
(78) Miscellaneous (Requires Desc.)	V2799	_____
(79) Other	_____	_____
CONTACT LENS FITTING SERVICES		
(80) Fitting for Treatment of Disease	92070	_____
(81) Fitting, Corneal (non-aphakic)	92310	_____
(82) Fitting 1 Eye, Corneal (aphakic)	92311	_____
(83) Fitting 2 Eyes, Corneal (aphakic)	92312	_____
(84) Other	_____	_____
CONTACT LENS MATERIALS		
# Lenses / Boxes	Right	Left
RT _____ LT _____	\$ _____	\$ _____
PMMA Gas Perm	Soft	FRP
(85) Spheric () V2500 () V2510 () V2520 () _____		
(86) Toric () V2501 () V2511 () V2521 () _____		
(87) Bifocal () V2502 () V2512 () V2522 () _____		
(88) Ext. Wear () V2513 () V2523 () _____		
(89) Miscellaneous (Requires Desc.) V2599	_____	_____
PQRI (1P/2P/3P/8P)		
(90) Pre-op cat eval	0014F	_____
(91) IOP dec by 15%	3284F	_____
(92) IOP not dec by 15%	3285F	_____
(93) Glauc plan of care	0517F	_____
(94) Optic Nerve Eval/POAG	2027F	_____
(95) AREDS counseling	4177F	_____
(96) Dil Macular Ex/AMD	2019F	_____
(97) Dil Macular Ex/DR	2021F	_____
(98) Dil Macular Ex/DM	2022F	_____
(99) 7 Field Photos (FP)/DM	2024F	_____
(100) Image=Dx from 7 FP/DM	2026F	_____
(101) Low Risk of Retinopathy	3072F	_____
(102) Letter to PCP/DM	5010F	_____
(103) Dil Macular Ex/DR/DM	G8397	_____
(104) Dil Mac Ex n/ DR/DM	G8398	_____
(105) All Rx w/ qual sys	G8443	_____
(106) All/Some Rx phoned in	G8446	_____
(107) No Rx generated	G8445	_____
(108) Ex doc w/ CCHIT EHR	G8447	_____
(109) Ex w/ non-CCHIT EHR	G8448	_____

RECALL	Days	Weeks	Months
Your Next Appointment is: _____ AM _____ PM			
Date _____ Time _____			
CONJUNCTIVA		LENS	
<input type="checkbox"/> Conjunctivitis		<input type="checkbox"/> After-Cataract,	
<input type="checkbox"/> Acute Atopic	372.05	<input type="checkbox"/> Not Obscuring Vision	366.52
<input type="checkbox"/> Acute Adenoviral Follicular	077.3	<input type="checkbox"/> Obscuring Vision	366.53
<input type="checkbox"/> Acute Follicular (Conjunctival Folliculosis,NOS)	372.02	<input type="checkbox"/> Aphakia	379.31
<input type="checkbox"/> Chronic Allergic, Other	372.14	<input type="checkbox"/> Cataract	
<input type="checkbox"/> Chronic, Unspec.	372.10	<input type="checkbox"/> Cortical Senile	366.15
<input type="checkbox"/> Conjunctival Hemorrhage	372.72	<input type="checkbox"/> Incipient	366.12
<input type="checkbox"/> Dis.of Conj. Due to Viruses, Unspec	077.99	<input type="checkbox"/> Nuclear	366.04
<input type="checkbox"/> Foreign Body, Conjunc. Sac	930.1	<input type="checkbox"/> Senile, Unspec.	366.10
<input type="checkbox"/> Laceration of Eye, Unspec.	871.4	<input type="checkbox"/> Total or Mature	366.17
<input type="checkbox"/> Pinguecula	372.51	<input type="checkbox"/> Post. Subcap. Polar Senile	366.14
<input type="checkbox"/> Pterygium, Unspec.	372.40	<input type="checkbox"/> Nuclear Sclerosis	366.16
<input type="checkbox"/> Pseudophakia		<input type="checkbox"/> Pseudophakia	V43.1
CORNEA		MISCELLANEOUS	
<input type="checkbox"/> Bullous Keratopathy	371.23	<input type="checkbox"/> Diabetes w/	250.5
<input type="checkbox"/> Corneal		<input type="checkbox"/> Ophthal. Manifestations	
<input type="checkbox"/> Abrasion	918.1	<input type="checkbox"/> Dizziness and Giddiness	780.4
<input type="checkbox"/> Changes, Senile	371.41	<input type="checkbox"/> Epiphora, Unspec.	375.20
<input type="checkbox"/> Dystrophy, Endothelial	371.57	<input type="checkbox"/> Headache	784.0
<input type="checkbox"/> Edema, Unspec.	371.20	<input type="checkbox"/> HIV	042
<input type="checkbox"/> Erosion, Recurrent	371.42	<input type="checkbox"/> Classical Migraine	346.0
<input type="checkbox"/> Foreign Body	930.0	<input type="checkbox"/> Common Migraine	346.1
<input type="checkbox"/> Opacity, Unspec.	371.00	<input type="checkbox"/> Nystagmus, Unspec.	379.50
<input type="checkbox"/> Herpes		<input type="checkbox"/> Pain In or Around Eye	379.91
<input type="checkbox"/> Simp. Disciform Keratitis	054.43	<input type="checkbox"/> Tear Film In suff., Unspec.	375.15
<input type="checkbox"/> Zoster Keratoconjunctivitis	053.21	<input type="checkbox"/> Visual Disturb., Spec., Other	368.8
<input type="checkbox"/> Keratoconjunct. Sicca, Not Sjogren's	370.33	<input type="checkbox"/> V.F. Defect, Unspec.	368.40
<input type="checkbox"/> Keratoconus, Unspec.	371.60	OPTIC NERVE	
<input type="checkbox"/> Laceration of Eye, Unspec.	871.4	<input type="checkbox"/> Drusen of Optic Disc	377.21
<input type="checkbox"/> Punctate Keratitis	370.21	<input type="checkbox"/> Glaucomatous Atrophy, Optic Disc	377.14
EYELID		<input type="checkbox"/> Optic Atrophy, Partial	377.15
<input type="checkbox"/> Blepharitis, Unspec.	373.00	<input type="checkbox"/> Optic Atrophy, Unspec.	377.10
<input type="checkbox"/> Blepharochalasis	374.34	<input type="checkbox"/> Optic Neuropathy, Ischemic	377.41
<input type="checkbox"/> Carcinoma, Eyelid	232.1	<input type="checkbox"/> Retrolbular Neuritis, Acute	377.32
<input type="checkbox"/> Chalazion	373.2	REFRACTION	
<input type="checkbox"/> Dermatochalasis	374.87	<input type="checkbox"/> Anisometropia	367.31
<input type="checkbox"/> Ectropion, Senile	374.11	<input type="checkbox"/> Astigmatism, Unspec.	367.20
<input type="checkbox"/> Entropion, Senile	374.01	<input type="checkbox"/> Hyperopia	367.0
<input type="checkbox"/> Hordeolum Externum	373.11	<input type="checkbox"/> Myopia	367.1
<input type="checkbox"/> Hordeolum Internum	373.12	<input type="checkbox"/> Presbyopia	367.4
<input type="checkbox"/> Neoplasm, Benign, Eyelid	216.1	RETINA	
<input type="checkbox"/> Open Wound, Adnexa, Spec.	870.8	<input type="checkbox"/> Artery Occlusion,	362.31
<input type="checkbox"/> Ptosis of Eyelid, Unspec.	374.30	<input type="checkbox"/> Central Retinal	
FUNCTIONAL		<input type="checkbox"/> Branch Occlusion, Arterial	362.32
<input type="checkbox"/> Amblyopia, Unspec.	368.00	<input type="checkbox"/> Diabetic Retinopathy	
<input type="checkbox"/> Binocular Vision Disorder, Unspec.	368.30	<input type="checkbox"/> Background	362.01
<input type="checkbox"/> Color Vision Deficiencies, Other	368.59	<input type="checkbox"/> Proliferative	362.02
<input type="checkbox"/> Convergence		<input type="checkbox"/> NOS, Non-Prolif.	362.03
<input type="checkbox"/> Excess or Spasm	378.84	<input type="checkbox"/> Mild, Non-Prolif.	362.04
<input type="checkbox"/> Insufficiency or Palsy	378.83	<input type="checkbox"/> Mod., Non-Prolif.	362.05
<input type="checkbox"/> Diplopia	368.2	<input type="checkbox"/> Severe, Non-Prolif.	362.06
<input type="checkbox"/> Esophoria	378.41	<input type="checkbox"/> Drusen, Degenerative	362.57
<input type="checkbox"/> Exophoria	378.42	<input type="checkbox"/> Lattice Degeneration	362.63
<input type="checkbox"/> Exotropia, Monocular	378.11	<input type="checkbox"/> Macular	
<input type="checkbox"/> Exotropia, Unspec.	378.10	<input type="checkbox"/> Cyst, Hole, or Pseudohole	362.54
<input type="checkbox"/> Hypertropia	378.31	<input type="checkbox"/> Degen., Senile, Exudative	362.52
<input type="checkbox"/> Legal Blindness, USA	369.4	<input type="checkbox"/> Degen., Senile, Nonexud.	362.51
GLAUCOMA		<input type="checkbox"/> Edema, Diabetic	362.07
<input type="checkbox"/> Angle-Closure, Chronic	365.23	<input type="checkbox"/> Puckering	362.56
<input type="checkbox"/> Ocular Hypertension	365.04	<input type="checkbox"/> Scars, Other	363.32
<input type="checkbox"/> Open-Angle		<input type="checkbox"/> Retinal	
<input type="checkbox"/> Glaucoma, Primary	365.11	<input type="checkbox"/> Defect, Unspec.	361.30
<input type="checkbox"/> Glaucoma, Suspect	365.01	<input type="checkbox"/> Degeneration, Peripheral	362.60
<input type="checkbox"/> Glaucoma, Unspec.	365.10	<input type="checkbox"/> Detachment w/ Ret. Defect	361.00
IRIS		<input type="checkbox"/> Edema	362.83
<input type="checkbox"/> Iridocyclitis		<input type="checkbox"/> Hemorrhage	362.81
<input type="checkbox"/> Acute and Subacute	364.00	<input type="checkbox"/> Retinopathy	
<input type="checkbox"/> Chronic	364.10	<input type="checkbox"/> Central Serous	362.41
<input type="checkbox"/> Primary	364.01	<input type="checkbox"/> Hypertensive	362.11
<input type="checkbox"/> Recurrent	364.02	<input type="checkbox"/> Vein Occlusion, Central Retinal	362.35
<input type="checkbox"/> Scleritis, Unspec.	379.00	<input type="checkbox"/> Venous Tributary (Branch) Occ.	362.36
OTHER		<input type="checkbox"/> Vitreous	
<input type="checkbox"/> _____		<input type="checkbox"/> Degeneration	379.21
<input type="checkbox"/> _____		<input type="checkbox"/> Opacities (Floaters), Other	379.24
<input type="checkbox"/> _____		<input type="checkbox"/> Hemorrhage	379.23

TOTALS	PROFESSIONAL SERVICES	\$ _____
	MATERIALS	\$ _____
	INSURANCE TOTAL	\$ _____
	PREVIOUS BALANCE	\$ _____
	TODAY'S PAYMENT ADJUSTMENT/MISC.	\$ _____
BALANCE DUE		\$ _____
ASSIGNMENT: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Doctor's Signature _____		
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Doctor for benefits otherwise payable to me for service as coded above: I understand that I am responsible for the balance of fees not paid by insurance.		
Signed (Patient or Parent if minor) _____ Date _____		
Please remember that payment is your obligation regardless of insurance or other third party involvement.		
NOTES		