MARYLAND MEDICAL ASSISTANCE PROGRAM

VISION CARE SERVICES PROVIDER MANUAL

(Provider Type 12)

(COMAR 10.09.14)

This manual is provided as a tool to assist in understanding Maryland Medicaid's coverage of these services and is to be used as a guide only. As a provider, it is your responsibility to adhere to established Program policies and regulations for these services.

July, 2010

Vision Care Services

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DEFINITIONS

1. **Acquisition Cost** means the actual cost of a product to a provider.

2. **Board** means the State Board of Examiners in Optometry.

3. **Diagnostically certified optometrist** means a licensed optometrist who is certified by the Board to administer topical ocular diagnostic pharmaceutical agents to the extent permitted under Health Occupations Article §11-404.

4. **Medically necessary** means a service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, family or provider.

5. **Ophthalmic lenses or optical aids** means a lens, contact lens, prism, or vision aid which has a therapeutic effect on a patient, or which will contribute to the visual welfare of a patient.

6. **Optician** means an individual, partnership, or company which meets applicable licensing requirements as a qualified grinder or dispenser of ophthalmic lenses or optical aids, and which is capable of translating, filling, and adapting ophthalmic prescriptions, products and accessories.

7. **Optometric clinic or center** means a facility that provides vision care services for patients under the supervision of a licensed optometrist.

8. **Optometric examination** means a series of tests and measurements used to determine the extent of visual impairment or the correction required to improve visual acuity performed by a licensed optometrist and includes as a minimum:

(a) Reviewing a patient's history, past prescriptions and specifications when indicated,

(b) Visual analysis,

(c) Ophthalmoscopy of internal eye,

(d) Tonometry when indicated or for a patient over 40 years of age,

(e) Muscle balance examination,

(f) Gross visual field testing when indicated

DEFINITIONS (continued)

8. (g) Writing of lens formula and other prescription data when needed as well as specific instructions for future care,

(h) Other tests when indicated by above, and

(i) Subsequent progress evaluation when indicated.

9. Optometrist means an individual who is licensed by the Board to practice optometry or by the state in which the service is rendered.

10.Orthoptic treatment means a category of visual training by use of instruments to measure and enhance the binocular coordination of the eyes.

11. Practice Optometry means:

(a) To use any means known in the science of optics or eye care, except surgery, subject to Health Occupations Article §11-404 and 11-404.2,:

(i) To detect, diagnose and treat any optical or diseased condition in the human eye,

(ii) To prescribe eyeglasses or lenses to correct any optical or visual condition in the human eye,

(iii) To give advice or direction on the fitness or adaptation of eyeglasses or lenses to any individual for the correction or relief of a condition for which eyeglasses or lenses are worn, and

(iv) to use or permit the use of any instrument, test card, test type, test eyeglasses, test lenses, or other device to aid in choosing eyeglasses or lenses for an individual to wear.

(b) And includes, subject to Health Occupations Article §11-404 and 11-402.2:

(i) The administration of topical ocular diagnostic pharmaceutical agents,

(ii) The administration and prescription of therapeutic pharmaceutical agents, and

(iii) The removal of superficial foreign bodies from the cornea and conjunctiva.

DEFINITIONS (continued)

12. Progress evaluation means a follow-up visit, when indicated, to determine the effectiveness of an optometric examination, prescription, or series of orthoptic treatments.

13. Routine adjustment means an adjustment made to an optical aid other than an adjustment required because of damage.

14. Therapeutically certified optometrist means a licensed optometrist who is certified by the Board to administer or prescribe therapeutic pharmaceutical agents or remove superficial foreign bodies from a human eye, adnexa, or lacrimal system to the extent permitted under Health Occupations Article §11-404.2.

15. Visual training means the use of instruments or other means to measure and enhance the binocular coordination of the eyes and visual perceptual functions.

Provider Enrollment:

PLEASE NOTE: UNDER THE MARYLAND MEDICAID PROGRAM, OPTOMETRISTS AND OPTICAL CENTERS THAT ARE PART OF A PHYSICIAN'S GROUP CANNOT BILL UNDER THE PHYSICIAN'S PROVIDER NUMBER. SERVICES RENDERED BY THE OPTOMETRIST OR OPTICAL CENTER CANNOT BE BILLED UNDER THE PHYSICIAN'S PROVIDER NUMBER. THESE PROVIDERS MUST COMPLETE AN ENROLLMENT APPLICATION AND BE ASSIGNED A MARYLAND MEDICAID PROVIDER NUMBER THAT HAS BEEN SPECIFICALLY ASSIGNED TO THEM. THE NUMBER WILL BE USED WHEN BILLING DIRECTLY TO MEDICAID FOR OPTOMETRIC OR OPTICAL CENTER SERVICES. CONTACT THE PROVIDER MASTERFILE OFFICE AT 410-767-5340 FOR AN ENROLLMENT PACKET FOR VISION SERVICES (provider type 12). (OPTHALMOLOGISTS ARE ENROLLED UNDER MEDICAID'S PHYSICIAN PROGRAM-provider type 20 and should follow the regulations and manual specific to that particular provider type.)

PROVIDER REQUIREMENTS

The provider must meet requirements as set forth in COMAR 10.09.36, General Medical Assistance Provider Participation Criteria, including:

1. Be licensed and legally authorized to practice optometry in the state in which the service is provided.

2. Verify a Medical Assistance recipient's eligibility prior to rendering services.

3. Maintain adequate records for a minimum of 6 years and make them available, upon request, to the Department or its designee.

PROVIDER REQUIREMENTS (continued)

4. Provide service without regard to race, creed, color, age, sex, national origin, marital status, or physical or mental handicap.

5. Not knowingly employ an optometrist or optician to provide services to Medical Assistance patients after that optometrist or optician has been disqualified from the Program, unless prior approval has been received from the Department.

6. Accept payment by the Department as payment in full for services rendered and make no additional charge to any person for covered services.

7. Use first quality materials that meet the criteria established by the Department.

8. Place no restrictions on recipients' right to select providers of their choice.

9. Agree that if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary, the provider may not seek payment for that service from the recipient or family members.

10. Agree that if the Program denies payment due to late billing, the provider may not seek payment for that service from the recipient or family members.

PATIENT ELIGIBILITY

Recipient must be Medicaid eligible on the date of service. The Office of Operations, Eligibility and Pharmacy, Medical Care Program has announced that two new patient Eligibility Verification Systems (EVS) are now available. Both are available to providers at no charge.

The new Interactive Voice Response (IVR) system replaces Medicaid's legacy voice response EVS with a new telephone access system that includes enhancements not available in the current EVS, such as:

- **One toll free number for the entire State. The number is 1-866-710-1447.**
- Managed Care Organization (MCO) transfer option - If the recipient is a member of an MCO, provider can press "3" and the call will be transferred directly to the MCO's call center to verify Primary Care Physician (PCP) assignment. For a recipient in a facility, provider will be given the name and phone number of the facility.

PATIENT ELIGIBILITY (continued)

- If you need to hear verification a second time, press "1" and the information will be repeated. Press "2" in order to enter the next recipient's information.
- If a mistake is made prior to pressing #, you can press "*" to go back and enter the information correctly.
- Past eligibility can now be obtained by entering the recipient's social security number, name code and date of service.

Providers may download the EVS/IVR user brochure, which contains additional details about the new system, by accessing the Department's website at www.dhmh.state.md.us/medcareprog.

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application, is now available at www.emdhealthchoice.org. Providers must be enrolled in eMedicaid in order to access EVS. To enroll and access WebEVS go to URL above, select 'Services for Medical Care Providers', and follow the login instructions. If you need information, please visit the website or for provider application support call 410-767-5340.

If you have questions concerning the new EVS system, please contact the Provider Relations Division at 410-767-5503 or 1-800-445-1159.

COVERED SERVICES

The Medical Assistance Program covers the following vision care services:

1. A maximum of one optometric examination to determine the extent of visual impairment or the correction required to improve visual acuity, every two years for recipients 21 years and older, and a maximum of one optometric examination a year for recipients younger than 21 years old, unless the time limitations are waived by the Program, based upon medical necessity.

2. A maximum of one pair of eyeglasses a year for recipients younger than 21 years old (unless the time limitations are waived by the Program, based on medical necessity) which have first quality, impact resistant lenses (except in cases where prescription requirements cannot be met with impact resistant lenses) and frames which are made of fire-resistant, first quality material, when at least one of the following conditions are met:

COVERED SERVICES (continued)

2. **(a)** The recipient requires a diopter change of at least 0.50,

(b) The recipient requires a diopter correction of less than 0.50 based on medical necessity and preauthorization has been obtained from the Program,

(c) The recipient's present eyeglasses have been damaged to the extent that they affect visual performance and cannot be repaired to effective performance standards, or are no longer usable due to a change in head size or anatomy, or

(d) The recipient's present eyeglasses have been lost or stolen.

3. Examination and eyeglasses for a recipient with a medical condition, other than normal physiological change necessitating a change in eyeglasses (before the normal time limits have been met) when a preauthorization has been obtained from the program.

4. Visually necessary optometric care rendered by an optometrist when these services are:

(a) provided by the optometrist or his licensed employee,

(b) Related to the patient's health needs as diagnostic, preventative, curative, palliative, or rehabilitative services, and

(c) Adequately described in the patient's record.

5. Optician services when they are:

(a) Provided by the optician or optometrist, or by an employee under their supervision and control,

(b) Adequately described in the patient's record, and

(c) Ordered or prescribed by an ophthalmologist or optometrist.

LIMITATIONS

1. The Vision Care Program does not cover the following services:

(a) Services not medically necessary,

(b) Investigational or experimental drugs or procedures,

(c) Services prohibited by the State Board of Examiners in Optometry,

(d) Services denied by Medicare as not medically justified,

LI**MITATIONS (continued)**

(e) Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients 21 years or older,

(f) Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to recipients younger than 21 years old which were not ordered as a result of a full or partial EPSDT screen,

(g) Repairs, except when repairs to eyeglasses are cost effective compared to the cost of replacing with new glasses,

(h) Repairs for recipients 21 or older,

(i) Combination or metal frames except when required for proper fit,

(j) Cost of travel by the provider,

(k) A general screening of the Medical Assistance population,

(l) Visual training sessions which do not include orthoptic treatment, and

(m) Routine adjustment.

2. The optometrist may not bill the Program nor the recipient for:

(a) Completion of forms and reports,

(b) Broken or missed appointments,
(c) Professional services rendered by mail or telephone,

(d) Services which are provided at no charge to the general public, and

(e) Providing a copy of a recipient's patient record when requested by another licensed provider on behalf of the recipient.

3. An optometrist certified by the Board as qualified to administer diagnostic pharmaceutical agents may use the following agents in strengths not greater than the strengths indicated:

(a) Agents directly or indirectly affecting the pupil of the eye including the mydriatics and cycloplegics listed below:

(i) Phenylephrine hydrochloride (2.5%),
(ii) Hydroxyamphetamine hydrobromide (1.0%),

LIMITATIONS (continued)

(iii) Cyclopentolate hydrochloride (0.5 - 2.0%),

(iv) Tropicamide (0.5 and 1.0%),

(v) Cyclopentolate hydrochloride (0.2%) with Phenylephrine hydrochloride (1.0%),

(vi) Dapiprazole hydrochloride (0.5%),

(vii) Hydroxyamphetamine hydrobromide (1.0%) and Tropicamide (0.25%).

(b) Agents directly or indirectly affecting the sensitivity of the cornea including the topical anesthetics listed below:

(i) Proparacaine hydrochloride (0.5%), and

(ii) Tetracaine hydrochloride (0.5%).

(c) Diagnostic topical anesthetic and dye combinations listed below:

(i) Benoxinate hydrochloride (0.4%) - Fluorescein sodium (0.25%), and

(ii) Proparacaine hydrochloride (0.5%) - Fluorescein sodium (0.25%).

4. An optometrist certified by the Board as qualified to administer and prescribe topical therapeutic pharmaceuticalagents is limited to:

(a) Ocular antihistamines, decongestants, and combinations thereof, excluding steroids,

(b) Ocular antiallergy pharmaceutical agents,

(c) Ocular antibiotics and combinations of ocular antibiotics, excluding specially formulated or fortified antibiotics,

(d) antiinflammatory agents, excluding steroids,

(e) Ocular lubricants and artificial tears,

(f) Tropicamide,

(g) Homatropine,

LIMITATIONS (continued)

(h) Nonprescription drugs that are commercially available, and

(i) Primary open-angle glaucoma medications, in accordance with a written treatment plan developed jointly between the optometrist and an ophthalmologist.

5. The Program will only pay for lenses to be used in frames purchased by the Program or to replace lenses in the recipient's existing frames, which are defined as those which have been fitted with lenses and previously worn by the recipient for the purpose of correcting that patient's vision.

(a) Providers may not sell a frame to a recipient as a private patient and bill the Program for the lenses only,

(b) Providers may not bill the Program for lenses when the recipient presents new, unfitted frames which were purchased from another source,

(c) Providers may not bill the Program for the maximum allowed fee for frames and collect supplemental payment from the recipient to enable that recipient to purchase a desired frame that exceeds Program limits, and

(d) If after the provider has fully explained the extent of Program coverage, the recipient knowingly elects to purchase the desired frames and lenses, the provider may sell a complete pair of eyeglasses (frames and lenses) to a recipient as a private patient without billing the Program.

PREAUTHORIZATION REQUIREMENTS

1. The following services require written preauthorization:

(a) Optometric examinations to determine the extent of visual impairment or the correction required to improve visual acuity before expiration of the normal time limitations,

(b) Replacement of eyeglasses due to medical necessity or because they were lost, stolen or damaged before expiration of the normal time limitations,

(c) Contact lenses,
(d) Subnormal vision aid examination and fitting,
(e) Orthoptic treatment sessions,

PREAUTHORIZATION REQUIREMENTS (continued)

(f) Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction,

(g) Absorptive lenses, except cataract, and

(h) Ophthalmic lenses or optical aids when the diopter correction is less than:

(i) - 0.50 D. sphere for myopia in the weakest meridian,
(ii) + 0.75 D. sphere for hyperopia in the weakest meridian,
(iii) + 0.75 additional for presbyopia,
(iv) ± 0.75 D. cylinder for astigmatism.
(vi) A change in axis of 5 degrees for cylinders of 1.00 diopter or more, and
(vii) A total of 4 prism diopters lateral or a total of 1 prism diopter vertical.

2. Preauthorization is issued when the provider submits to the Program adequate documentation demonstrating that the service to be preauthorized is medically necessary. ("medically necessary" means that the service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability, or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, their family or the provider.)

3. Preauthorization is valid only for services rendered or initiated within 60 days of the date issued.

4. Preauthorization must be requested in writing. A Preauthorization Request Form for Vision Care Services (DHMH 4526) must be completed and submitted to:

Medical Care Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, MD 21203

Documentation substantiating medical necessity must be attached to the preauthorization request. A copy of the patient record report and/or notes describing the service must be included with the request. If available, include a copy of the laboratory invoice at this time. Otherwise, a copy of the invoice must be attached to the claim for proper pricing of the item after the service has been authorized by the Program.

PREAUTHORIZATION REQUIREMENTS (continued)

5. Procedure codes followed by a "**P**" in this manual require written preauthorization.

6. The Program will cover medically justified contact lenses for recipients younger than 21 years old. The following criteria are used when reviewing written preauthorization requests for contact lenses:

(a) Monocular Aphakia.

(i) When visual acuity of the two eyes is equalized within two lines (standard Snellen designation),

(ii) When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage, and

(iii) When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

(b) Anisometropia.

(i) When the prescriptive difference between the two eyes exceeds 4.00 diopters (S.E.) and visual acuity of the two eyes is equalized within two lines,

(ii) When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage, and

(iii) When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

(c) Keratoconus/Corneal Dyscrasies.

(i) When contact lenses are accepted as the treatment of choice relative to the phase of a particular condition,

(ii) When the best spectacle correction in the best eye is worse than 20/60 and when the contact lens is capable of improving visual acuity to better than 20/40 or four lines better than the best spectacle acuity, and

(iii) When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage.

PAYMENT PROCEDURES

The provider shall submit a request for payment on the billing form CMS-1500. The request for payment must include any required documentation, such as, preauthorization number, need for combination or metal frame, patient record notes, and laboratory invoices, when applicable. Maryland Medicaid Billing Instructions for the CMS-1500 can be obtained from Provider Relations at (410) 767-5503 or (800) 445-1159.

The Medical Assistance Program has established a fee schedule for covered vision care services provided by optometrists and optical centers (MD MA provider type 12). The fee schedule lists all covered services by CPT-4 and national HCPCS codes and the maximum fee allowed for each service. Vision care providers must bill their usual and customary charge to the general public for similar professional services. The Program will pay professional fees for covered services the lower of the provider's usual and customary charge or the Program's fee schedule. For professional services, providers must bill their usual and customary charges. The Program will pay for materials at acquisition costs not to exceed the maximum established by the Program. For materials, providers must bill their acquisition costs.

Where a **"By Report" BR** status is indicated on the schedule, attach a copy of the lab invoice to the claim for pricing purposes as well as the records to substantiate medical necessity(record report/notes describing the service).

When the fee for a vision care procedure is listed as **"Acquisition Cost"** (**A.C.**) in this manual, the value of the procedure is based on acquisition cost. Bill the Program the acquisition cost for the item. The lab invoice substantiating the charge as well as other records must remain on file for a 6 year period and made available upon request by the Program.

Procedures with a preauthorization requirement **(P)** must be authorized prior to treating the patient. If the procedure is authorized, the preauthorization number must appear on the claim.

The provider must select the procedure code that most accurately identifies the service performed. Any service rendered must be adequately documented in the patient record. The records must be retained for **6** years. Lack of acceptable documentation may cause the Program to deny payment, or if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit.

The **NFAC** (Non-Facility) fee is paid for place of service 11, 12 and 62. The **FAC** (facility) fee is paid for all other POS's.

PAYMENT PROCEDURES (continued)

Payments for lenses, frames, and the fitting and dispensing of spectacles include any routine follow-up and adjustments for 60 days. No additional fees will be paid. Providers must bill and will be paid for the supply of materials at acquisition costs not to exceed the maximum established by the Program. If a maximum has not been established, the provider must attach laboratory documentation to the invoice. **Fitting includes** facial measurements, frame selection, prescription evaluation and verification and subsequent adjustments. The maximum fee for lenses includes the cost for FDA hardening, testing, edging, assembling and surfacing. The maximum fee for frames includes the cost of a case.

(a) Use the following procedure codes for the billing of frames:

(i) V2020 for a child/adult ZYL frame,

(ii) V2025 for a metal or combination frame when required for a proper fit,

(iii) V2799 (preauthorization required) for a special or custom frame when necessary and appropriate, and

(b) Use procedure codes **92340 - 92342** for the fitting of spectacles.

(c) Use procedure code **92370** and attach a copy of the lab invoice to the claim when billing for a repair. Please note: Repair charges not traditionally billed to the general public cannot be billed to Maryland Medicaid. (Review the regulations for coverage of eyeglass repairs.)

Contact lens services require preauthorization and include the prescription of contact lenses (specification of optical and physical characteristics), the proper fitting of contact lenses (including the instruction and training of the wearer, incidental revision of the lens and adaptation), the supply of contact lenses, and the follow-up of successfully fitted extended wear lenses. Use the following procedure codes for the billing of these services:

(a) 92310-26 for the professional services of prescription, fitting, training and adaptation,

(b) V2500 - V2599 for contact lenses, and

PAYMENT PROCEDURES (continued)

(c) 92012 for follow-up subsequent to a proper fitting.

Vision care claims must be received within **9** months of the date that services were rendered. If a claim is received within the 9-month limit but rejected due to erroneous or missing data, resubmittal will be accepted within 60 days of rejection or within 9-months of the date that the service was rendered, whichever is later. If a claim is rejected because of late receipt, the recipient may not be billed for that claim.

Medicare/Medicaid Crossover claims must be received within **120** days of the date that payment was made by Medicare. This is the date of Medicare's Explanation of Benefits form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

6. The Medical Assistance Program is always the payer of last resort. Whenever a Medical Assistance recipient is known to be enrolled in Medicare, Medicare must be billed first. Claims for Medicare/Medicaid recipients must be submitted on the CMS-1500 directly to the Medicare Intermediary.

When billing Medicare on the CMS-1500 form, place the letters "**MMA**" (Maryland Medical Assistance) and the recipient's 11-digit identification number in Block 9a and check "**Accept Assignment**" in Block 27. This will assure that Medicare will automatically forward the appropriate information to the Program which is responsible to pay for the deductible or coinsurance. Also make certain to check both **Medicare** and **Medicaid** in Block 1 on the top of the CMS-1500 so as not to delay any payments due.

For additional information about the MD Medicaid Program, go to:

www.dhmh.state.md.us/mma/providerinfo

A copy of the regulations can be viewed at the following website:
www.dsd.state.md.us/comar (title 10) (subtitle 09) 10.09.14

PROFESSIONAL SERVICES/MATERIALS REIMBURSEMENTS-PROVIDER TYPE 12

CPT-4/ HCPCS		DESCRIPTION	MAXIMUM PAYMENT	NFAC	FAC
65205		Remve forgn body,ext conj suprf		36.93	29.58
65210		Remve forgn body conj embedded		45.16	35.78
65220		Remve forgn body cornl w/o lamp		38.09	29.55
65222		Remve forgn body corneal w/lamp		45.56	38.84
92002		Eye exam,new patient,interme.		51.18	34.91
92004		Eye exam,new patient,comprehen.		95.93	69.50
92012		Eye exam,estab.patient,interme.		54.13	34.73
92014		Eye exam,estab.patient,comprehen.		78.43	53.48
92015		Determ. Refractive State		32.56	14.72
92020		Gonioscopy		18.44	14.77
92025		Computerized Corneal Topography		24.19	25.67
92060		Sensorimtr exam w/multiple meas.		40.86	43.37
92065	P	Orthoptic/pleoptic training	*	30.78	32.67
92070	P	Fitting of contact lens [For Treatment of Disease]	*	48.10	29.18
92081		Visual field exam(s)limited		38.40	40.69
92082		Visual field exam(s)interm.		49.99	53.05
92083		Visual field exam(s)extended		57.44	60.96
92100		Serial tonometry exam(s)		62.57	36.84
92120		Tonography & eye evaluation		51.58	32.36
92130		Tonography w/water provocation		57.91	33.68
92140		Glaucoma provoc.tests w/o tono.		41.18	20.19
92225		Ophthalmoscopy,initial		16.64	14.77
92226		Ophthalmoscopy,subsequent		15.19	13.25
92250		Fundus photography w/inter+rpt		52.21	57.53
92260		Ophthalmodynamometry		12.65	8.66
92283		Color vision exam.,ext.		32.28	34.26
92285		Ext ocular photo.w/inter+report		32.54	34.53
92286		Special ant.segmnt photography		94.86	100.67
92310	P	Contact lenses fitting	*	66.10	45.74
92311	P	Contact lens fitting-1/aphakia	*	66.10	41.91
92312	P	Contact lens fitting-2/aphakia	*	73.75	49.95
92313	P	Contact lens fitting/corneo.	*	61.07	36.17
92325	P	Modification of contact lens	*	18.98	20.14
92326	P	Replacement of contact lens	*	37.27	39.56
92340		Fitting of spectacles,monofocal		28.88	14.38
92341		Fitting of spectacles,bifocal		30.08	17.91
92342		Fitting of spectacles,multifocal		32.38	20.80
92354	P	Fitting of spec mntd low vsn aid	*	97.70	149.55
92355	P	Fitting of spec/telescopic,other	*	56.05	76.76
92370		Repair & refitting spectacles (except for aphakia)		22.73	12.28
92499	P	Unlisted eye service or proc.	B.R.*		
S0595		Lens,new,patient supplied frame	N/C		
V2020		Adult/child ZYL frames w /case	8.50		
V2025		Metal or combination frame	12.00		
V2100		Lens spher single plano 4.00	5.00		
V2101		Single visn sphere 4.12-7.00	7.20		
V2102		Single visn sphere 7.12-20.00	22.15		
V2103		Spherocylndr,SV, 4.00d/.12-2.00	5.80		
V2104		Spherocylndr,SV, 4.00d/2.12-4d	6.30		

***Preauthorization required prior to treatment**

CPT-4/ HCPCS		DESCRIPTION	MAXIMUM PAYMENT
V2105		Spherocylndr,SV,4.00d/4.25-6d	7.30
V2106		Spherocylndr,SV,4.00d/over6.00d	B.R.
V2107		Spherocylndr,SV,+-4.25d/.12-2d	7.70
V2108		Spherocylndr,SV,+-4.25d/2.12-4d	8.20
V2109		Spherocylndr,SV,+-4.25d/4.25-6d	9.20
V2110		Spherocylndr,SV,+-4.25d/over 6d	B.R
V2111		Spherocylndr,SV,+-7.25d/.25-2.25d	22.15
V2112		Spherocylndr,SV,+-7.25d/2.25-4d	19.00
V2113		Spherocylndr,SV,+-7.25d/4.25-6d	A.C.
V2114		Spherocylndr,SV,over +-12.00d	36.00
V2115		Lenticular(myodisc),SV	B.R.
V2118	P	Aniseikonic,SV	A.C.*
V2121		Lenticular Lens, Per Lens, Single	A.C.
V2199	P	Not otherwise classified,SV lens	A.C.*
V2200		Sphere,bifcl,plano +-4.00d	11.00
V2201		Sphere,bifcl,+-4.12/+-7.00d	13.00
V2202		Sphere,bifcl,+-7.12/+-20d	A.C.
V2203		Spherocylndr,BF,4.00d/.12-2.00d	13.50
V2204		Spherocylndr,BF,4.00d/2.12-4	14.50
V2205		Spherocylndr,BF,4.00d/4.25-6	16.50
V2206		Spherocylndr,BF,4.00d/over 6	A.C.
V2207		Spherocylndr,BF,4.25-7/.12to2	14.50
V2208		Spherocylndr,BF,4.25+-7/2.12to4	15.50
V2209		Spherocylndr,BF,4.25+-7/4.25-6	17.50
V2210		Spherocylndr,BF,4.25+-7/over 6	A.C.
V2211		Spherocylndr,BF,7.25+-12/.25-2.25	A.C.
V2212		Spherocylndr,BF,7.25+-12/2.25-4	A.C.
V2213		Spherocylndr,BF,7.25+-12/4.25-6	A.C.
V2214		Spherocylndr,BF,sph over +-12.00d	A.C.
V2215		Lenticular(myodisc) bifocal	B.R.
V2218	P	Aniseikonic, bifocal	A.C.*
V2219	P	Bifocal seg width over 28 mm	A.C.*
V2220	P	Bifocal add over 3.25d	A.C.*
V2221		Lenticular lens, bifocal	24.00
V2299	P	Specialty bifocal(by report)	A.C.*
V2300		Sphere,trifcl,pl+-4.00d	16.50
V2301		Sphere,trifcl +-4.12/-7.00d	19.00
V2302		Sphere,trifcl +-7.12/+-20.00	A.C.
V2303		Spherocylndr,trifcl,pl+-4/.12-2	18.00
V2304		Spherocylndr,trifcl,p+-4/2.25-4	20.50
V2305		Spherocylndr,trifcl,p+-4/4.25-6	24.00
V2306		Spherocylndr,trifcl,p+-4/over 6	A.C.
V2307		Spherocylndr,trifcl,+-4.25/…2d	20.50
V2308		Spherocylndr,trifcl,+-4.25/…4d	22.00
V2309		Spherocylndr,trifcl,+-4.25/…6d	25.00
V2310		Spherocylndr,trifcl,+-4.25/over6d	A.C.
V2311		Spherocylndr,trifcl,+-7.25/…2.25d	A.C.

*Preauthorization required prior to treatment

CPT-4/ DESCRIPTION			MAXIMUM PAYMENT	HCPCS
V2312		Spherocylndr,trifcl,+-7.25/…4.00d	A.C.	
V2313		Spherocylndr,trifcl,+-7.25/…6.00d	A.C.	
V2314		Spherocylndr,trifcl,over p-12.00d	A.C.	
V2315		Lenticular(myodisc), trifocal	A.C.	
V2318	P	Aniseikonic lens, trifocal	A.C.*	
V2319	P	Trifocal seg width over 28 mm	A.C.*	
V2320	P	Trifocal add over 3.25d	A.C.*	
V2321		Lenticular lens,trifocal	A.C.	
V2399	P	Specialty trifocal(by report)	A.C.*	
V2410	P	Variable asph,SV,full fld,gl/pl	A.C.*	
V2430	P	Variable asph,bifcl,full fld,g/p	A.C.*	
V2499	P	Variable sphericity, other type	A.C.*	
V2500	P	Contact lens pmma spherical	50.00*	
V2501	P	Contact lens pmma toric/prism	50.00*	
V2502	P	Contact lens pmma bifocal	50.00*	
V2503	P	Cntct lens pmma color vision def	50.00*	
V2510	P	Cntct lens gas permeable spher	50.00*	
V2511	P	Cntct lens gas permbl toric,pri	50.00*	
V2512	P	Cntct lens gas permbl bifocl	50.00*	
V2513	P	Cntct lens gas perm ext wear	50.00*	
V2520	P	Cntct lens hydrophilic spere	70.00*	
V2521	P	Cntct lens hydro toric,prism	70.00*	
V2522	P	Cntct lens hydrophil bifocal	70.00*	
V2523	P	Cntct lens hydrophil ext wear	70.00*	
V2530	P	Cntct lens,scleral,gas imperm	A.C.*	
V2599	P	Contact lens, other type	A.C.*	
V2600	P	Hand held low vision aids & oth	A.C.*	
V2610	P	Single lens spectacle mount lva	A.C.*	
V2615	P	Telescopic & oth compound lens	A.C.*	
V2700		Balance lens	A.C.	
V2702		Deluxe lens feature	N/C	
V2715	P	Prism lens	A.C.*	
V2718	P	Press-on lens,Fresnel prism	A.C.*	
V2745		Add.tint,any color/solid/grad	B.R.	
V2784		Polycarbonate lens, any index [Greater than 6 Diopters or other medically necessary condition]	A.C.	
V2799	P	Vision service,miscellaneous	A.C.*	

* Preauthorization required prior to treatment.

When the fee for a vision care procedure is listed as "**By Report**" (**B.R.**) on this schedule a copy of the optometrist's patient record report and/or notes which describe the services rendered and the lab invoice must be submitted with the claim.

When the fee for a vision care procedure is listed as "**Acquisition Cost**" (**A.C.**) on this schedule, the value of the procedure is to be determined from a copy of a current laboratory or other invoice which clearly specifies the unit cost of the item.

When the fee for a vision care procedure is listed with an asterisk (*), a request for preauthorization must be submitted on form DHMH 4526. A copy of the patient record report and/or notes describing the services must be submitted to the Program prior to rendering the service.

The maximum fee for lenses includes the cost for FDA hardening, testing, edging, assembling and surfacing. The maximum fee for frames includes the cost of a case

Services provided must be medically necessary.

MARYLAND MEDICAL ASSISTANCE PROGRAM
MOST FREQUENTLY REQUESTED TELEPHONE NUMBERS

CHILDREN'S HEALTH PROGRAM (CHPs)	(800) 456-8900
ELIGIBILITY VERIFICATION SYSTEM (EVS)	1-866-710-1447
GENERAL PROVIDER RELATIONS	
Claims Resolution (Billing Questions, Payment Issues)	(410) 767-5503 or (800) 445-1159
Tape Billing - technical problems	(410) 767-5977
Third-Party Liability (other insurance)	(410) 767-1765
Missing Payment Voucher/Lost or Stolen Check	(410) 767-5344
Recoveries	(410) 767-1783
Medicaid Liaison Unit	(410) 767-6024
HEALTHCHOICE (Managed Care Organizations)	
Key Facts, Benefits and Services	(410) 767-1482
Enrollment Broker	(800) 977-7388
Provider Hotline	(800) 766-8692
Recipient Hotline	(800) 284-4510
PUBLIC MENTAL HEALTH SYSTEM	1-800-565-9688
CASE MANAGEMENT [REM]	1-800-565-8190
MEDICAID POLICY/COVERAGE ISSUES	
Audiology Services (410) 767-1722	
School Based Health Centers	(410) 767-5706
IEP/IFSP SERVICES	(410) 767-1903
DENTAL SERVICES	(410) 767-5706
DME/DMS	(410) 767-1476
Preauthorization-disposables	(410) 767-1739
Preauthorization-durable medical	(410) 767-1739
Preauthorization: Audiology and Vision -EPSDT population - under the age of 21	(410) 767-1722
Preauthorization-Private Duty Nursing	(410) 767-1712
Healthy Kids/EPSDT Program	(410) 767-1683
Healthy Start/Family Planning	(410) 767-6750
Laboratory	(410) 767-5706
Model Waiver	(410) 767-5220
Physicians/Nurse Practitioners	(410) 767-1722
Autism Waiver	(410) 767-5220
PREGNANT WOMEN AND CHILDREN'S INFORMATION HOTLINE	(800) 456-8900
PROVIDER MASTER FILE (ENROLLMENT) (Application, Address Changes)	(410) 767-5340

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION I - Patient Information

Medicaid Number |_|_|_|_|_|_|_|_|_|_|_|_|

Name _____ DOB _____ Sex ___ Telephone (___) _____
(Last) (First) (MI)

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number |_|_|_|_|_|_|_|_|_|

Name _____ Date Service Requested by Provider _____

Address _____

Contact _____ Telephone (___) _____

Provider's Signature _____

SECTION III - Additional Preauthorization Information

Give Reason(s) for Requested Service

_____

_____

SECTION IV - Preauthorization Line Item Information

DESCRIPTION OF SERVICE	PROCEDURE CODE	REQUESTED UNITS	REQUESTED AMOUNT	AUTHORIZED UNITS	AUTHORIZED AMOUNT
			$		$
			$		$
			$		$
			$		$
			$		$

PREAUTHORIZATION NUMBER

|_|_|_|_|_|_|_|_|_|_|_|_|

DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: Program Systems and Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

DMH 4326 Rev. 3/97

SEE REVERSE SIDE

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION V - Specific Program Preauthorization Information

New Prescription: O.D. _____ Best Visual Acuity _____

O.S. _____ Best Visual Acuity _____

CONTACT LENS REQUESTS:

Health Condition of each eye: O.D. _____ O.S. _____

Date of Surgery: O.D. _____ O.S. _____

Best visual acuity with contact lenses: O.D. _____ O.S. _____

Advantage of contact lenses over glasses: _____

_____

SECTION VI (DHMH Only)

_____APPROVED _____DENIED _____RETURNED

REASON(s) _____

MEDICAL CONSULTANT'S SIGNATURE: _____ DATE_____

PA - 2

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLKLUNG ☐ (SSN) 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. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE 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. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. | 3. |

2. | 4. |

22. MEDICAID 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. BALANCE DUE $

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Not official copy of CMS1500

Vision Manual - Provider Type 12
Optician/Optometrist/Optometric Center
07/10

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.