



QUIZ #20—ENCOUNTER FORM (#1 BONNIE SCHMIDT)

Surgical Practice of Colorado
482 Lake Drive
Yourtown, CO 80000
970-555-6456

Janice Ottaman, M.D. &
 Jim Wiseman, M.D.

CODE	NEW PATIENT	FEE	CODE	EXC. SUB Q & SKIN LES.	FEE	CODE	OFFICE SURGERY	FEE	CODE	99070 SURG. TRAYS ROOM	FEE
99201	Level 1			Area:			LYMPHATIC			99070R	Trays: Small Med. Large X-Large
99202	Level 2			Size:		38500	Bx or Excise Lymph Node		99070R	Room: (supplies included)	
99203	Level 3			Benign / Malign / Unknown		38505	Bx Lymph Node Needle		99070L	Irrigation Tray	
99204	Level 4					38510	Bx or Excise Cervical Node		A4550	Medicare Surgical Tray	
99205	Level 5					38525	Bx Deep Axillary Node				
ESTABLISHED PATIENT			OFFICE SURGERY						99072 ANESTHETIC		
99211	Level 1			INTEGUMENTARY					J3360	Valium	
99212	Level 2		10060*	I&D Abscess/Furuncle			DIGESTIVE		J3490	Versed	
99213	Level 3		10061*	I&D Abscess, Complex		46320*	I&D Thrombosed Hemorrhoid		J0990	Demerol	
99214	Level 4		10120*	Removal Foreign Body, Simple		46250	Simple Hemorrhoidectomy			Other	
99215	Level 5		10121*	Removal Foreign Body, Complex		46221	Hemorrhoid Banding/Ligation				
99024	Post Op					46600	Anoscopy				
CONSULTATIONS									SUPPLIES GIVEN TO PATIENT:		
99241	Level 1		11770	Excise Pilonidal Cyst, Simple		45300	Proctosigmoidoscopy				
99242	Level 2	30	11771	Extensive		45305	with Biopsy				
99243	Level 3		11772	Complex		45308	with Polyp Removal				
99244	Level 4					45330	Flexible Sigmoidoscopy				
99245	Level 5					45331	with Biopsy				
SECOND OPINION CONSULTS									OTHER PROCEDURES:		
99271	Level 1		19000*	Aspiration Breast Cyst		46050	I&D Perirectal Abscess				
99272	Level 2		19001	Additional Cyst							
99273	Level 3		19100*	Needle Biopsy, Breast							
99274	Level 4		19120	Excisional Biopsy, Breast							
99275	Level 5		19125	Biopsy Breast w/Localization		19000*	Aspiration Thyroid Nodule/Cyst				
			19140	Gynecomastectomy							
DIAGNOSIS											
769.0	Abdominal Pain			Cancer, Specify site		455.4	Hemorrhoids, Ext/Int/Thrombosed		685.1	Pilonidal Cyst	
566	Abscess/Anal/Rectal		V10.05	History of Colon Cancer		553	Hernia, specify site		685.0	Pilonidal Cyst with Abscess	
565.0	Anal Fissure		V70.0	History of Lung Cancer		242.90	Hyperthyroidism		512.8	Pneumothorax	
565.1	Anal Fistula		575.8	Biliary Dyskinesia		252.0	Hyperparathyroidism		998.5	PostOperative Infection	
540.9	Appendicitis, Acute		575.0	Cholecystitis/Acute		558.9	Inflammatory Bowel Dis/Colitis		569.3	Rectal Bleeding	
611	Breast		575.1	Cholecystitis/Chronic		214	Lipoma, specify site		787.9	Rectal Mass	
793.8	Abnormal Mammogram		574.10	Cholelithiasis/Cholecystitis		785.6	Lymphadenopathy		560.9	Small Bowel Obstruction	
611.71	Breast Pain		562.11	Diverticulitis		202.80	Lymphoma		706.2	Sebaceous Cyst	
V10.03	History of Breast Cancer		562.00	Diverticulosis		172.9	Melanoma		241.1	Thyroid, multi nodular	
611.72	Breast Mass UOQ UIQ LOQ LIQ		585	GERD		784.2	Mass: Head/Neck		241.0	Thyroid Nodule	
610.0	Breast Cyst		530.81	GI Bleed		533	Peptic Ulcer, Specify site, chronic/acute, Hem/perf		454.1	Venocose Veins	
610.1	Breast, Cystic Mastopathy		611.1	Gynecomastia		440.2	Peripheral Vascular Disease		787.0	Vomiting	

DATE: 5-10-XX TIME: 8:30 PATIENT: Bonnie Schmidt REASON: consult

TICKET NO: DR. # DOCTOR: Jim Wiseman LOCATION: office DOB: 6-25-1952

PATIENT NO: 821 RESPONSIBLE PARTY: Bonnie Schmidt PHONE: REFERRING DR: Fred Hobit, MD

SEX: M ADDRESS: 1810 Bluegrass Dr. CITY/STATE: Springtown, CO ZIP: 80002

OVER 90 OVER 60 OVER 30 CURRENT TOTAL DUE P.T. B.C. C.S. PAYMENT CHOICE: CASH INS CHG CR CARD

INSURANCE COMPANY: BA SCT POLICY IDENTIFICATION: RELATIONSHIP: NEXT APPOINTMENT: Days Weeks Months

DIAGNOSIS/NOTES: 727.1 Bunionette Consult for Dr. Hobit

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to my dependent. I understand I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Bonnie Schmidt
PATIENT/RESPONSIBLE PARTY



QUIZ #20—ENCOUNTER FORM (#2 KRISTY ARNOLD)

Dr. Fred Hobit, M.D.
24 Mockingbird Lane
Youngstown, Co. 80004

						Date of Service:			
						03	13	XX	
Acct. #		Patient name:			Responsible party:				
3131		Kristy Arnold			Barbara Arnold				
	Description	CPT	Fee	Description	CPT	Fee	Description	CPT	Fee
	Office or other outpatient service			Therapy			X-ray		
	New patient level 1	99201		Exercises	97110		Cervical spine	72040	
	New patient level 2	99202		Gait Training	97116		T-spine	72070	
	New patient level 3	99203					Lumbar spine	72100	
	New patient level 4	99204		Casts			Scoliosis	72090	
	New patient level 5	99205		Long Arm	29065		Pelvis	72170	
	Established Patient			Short Arm	29075		Hip	73510	
	Est. patient level 1	99211		LA splint	29105		Clavicle	73000	
	Est. patient level 2	99212		SA splint	29125		Shoulder	73030	
	Est. patient level 3	99213		Long leg	29345		Humerus	73060	
	Est. patient level 4	99214		Short leg	29405		Elbow	73070	
X	Est. patient level 5	99215	100.00	Walking	29425		Wrist	73100	
	Emergency department			PTB	29435		Hand	73120	
	New or est. level 1	99281		Cylinder	29365		Finger	73140	
	New or est. level 2	99282		Leg splint	29515		Femur	73550	
	New or est. level 3	99283		Cast removal-leg	29700		Knee	73560	
	New or est. level 4	99284		Cast removal-arm	29705		Leg	73590	
	New or est. level 5	99285		Sling	99070		X Ankle	73600	50.00
ICD-9-CM DIAGNOSTIC CODES									
X	Ankle sprain	845.00		Forearm Fx	813.83		Lumbar hernia disk	722.1	
	Ankle Fx	824.8		Ganglion	727.43		Lumbar sprain	846.0	
	Arm Fx	812.20		Carpal Tunnel	354.0		Lumbar Fx	805.8	
	Elbow sprain	841.9		Hand Fx	815.00		Neck Sprain	847.0	
	Elbow Fx	812.40		Wrist Fx	814.00		Neck hernia disk	722.0	
	Femur Fx	820		Hip Fx	820		Osteomyelitis	730	
	Finger sprain	842.13		Hip Deg	715.95		Pelvis Fx	808.59	
	Finger Fx	816.00		Knee Deg	715.96		Scoliosis congenital	754.2	
	Foot Fx	825.25		Knee sprain	844.9		Shoulder dislocation	831.01	
Surgery:							Previous Balance		
_____							\$		
_____							Today's Charge		
_____							\$ 150.00		
_____							Cash		
_____							\$		
Hospital:							Check		
_____							\$.00		
Diagnosis:							Current Balance		
_____							\$ 150.00		
ICD-9-CM code:							_____		
Physician's signature: Fred Hobit, M.D.							_____		

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Barbara Arnold
Signature of patient (or parent of minor child)

M.D.



QUIZ #20—ENCOUNTER FORM (#3 REBECCA BLOOMQUIST)

SPRINGTOWN CLINIC
1824 PARK AVENUE
SPRINGTOWN, CO 80002

Matthew Grimm, M.D.
 David Rhodes, M.D.

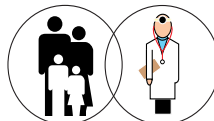
DATE OF SERVICE **02 / 24 / xx**

Telephone (970)		Fee
<input checked="" type="checkbox"/> 11	<input type="checkbox"/> 22	<input type="checkbox"/> 21
<input type="checkbox"/> 12	<input type="checkbox"/> 31	
NIGHT/SATURDAY CLINIC		99050
OFF	OP	IP
HOME	NH	
AFTER HOURS SERVICE		99052
FACILITY NAME		
OFFICE SERVICE	Code	Fee
	New	Estab
Brief	99201	99211
Limited	99202	99212 50
Interm	99203	99213
Extend	99204	99214
Compre	99205	99215
Phone Call - Brief	99371	
Phone Call - Interm.	99372	
Phone Call - Lengthy	99373	
HOSPITAL SERVICE		
DT ADMIT	DT DIS	
Incision & Drainage		
Intermediate	99222	
Comprehensive	99223	
Subsequent		
Limit #	@	99231
Inter #	@	99232
Extend #	@	99233
Critical Care	99291	
Discharge Management	99238	
Newborn Care Initial	99431	
Newborn Follow Up	99433	
Newborn Resuscitation	99440	
ER SERVICES		
Limit	99282	
Interm	99283	
Extend	99284	
Comprehensive	99285	
WELL CHILD CARE		
Adolescent (12-17)	99394	
Late Childhood (5-11)	99393	
Early Childhood (1-4)	99392	
Infant (<1)	99391	
IMMUNIZATIONS AND INJECTIONS		
<input type="checkbox"/> DPT	90701	
<input type="checkbox"/> CPV	90712	
<input type="checkbox"/> DT	90702	
<input type="checkbox"/> Haemophilus B	90737	
<input type="checkbox"/> Hepatitis B	90731	
<input type="checkbox"/> PPD	86585	
<input type="checkbox"/> Influenza	90724	
<input type="checkbox"/> Pneumococcal	90732	
<input type="checkbox"/> Tetramune	90720	
<input type="checkbox"/> Triple Vaccine MMR	90707	
Therapeutic	90782	
Drug Name		
Allergy Shot	95120	
OTHER SERVICES		

PATIENT'S NAME (PLEASE PRINT) Rebecca Bloomquist			
INSURANCE COMPANY NAME Med Link HMO		EMPLOYER Wilton Bookstore	
SUBSCRIBER NO. OR INSURED'S I.D. NO. 521-00-900602		GROUP NO. WBHMO	
SUBSCRIBER'S NAME Dick		RELATIONSHIP TO PATIENT Parent	
SUBSCRIBER'S ADDRESS 409 Yorkshire		CITY Yourtown	STATE CO
ZIP CODE	PATIENT'S SEX M <input checked="" type="radio"/> F	Check Patient's Relationship to Insured 1 Self 2 Spouse 3 Child <input checked="" type="checkbox"/> 4 Other	
PATIENT'S BIRTHDATE Mo. Day Year 6-25-97	DATE OF ACCIDENT OR ONSET 2-24-xx	PATIENT'S TELE NO. 555-5875	
REQUIRED: CHECK "YES" OR "NO" AS APPLIES TO THESE SERVICES			
Work-Related <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Caused By Another Party <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Patient Has Other Insurance <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Auto Accident <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medicare Eligibility <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
IF YOU CHECKED "YES" TO ANY OF THE ABOVE PROVIDE THE FOLLOWING OTHER INSURANCE COVERAGE INSURED'S I.D. NO.			
I certify to the accuracy of the above patient information and authorize the release of any medical information necessary to process this claim. I request payment of insurance benefits to either myself or the provider listed below			
Signed Dick Bloomquist		Date 02 / 24 / XX	
FAMILY PRACTICE — DIAGNOSTIC CODES: ICD-9-CM			
<input type="checkbox"/> 789.0 Abdominal Pain	<input type="checkbox"/> 558.9 Gastroenteritis	<input type="checkbox"/> 784.0 Headache	<input type="checkbox"/> 477.9 Allergic Rhinitis
<input type="checkbox"/> 536.8 Acid peptic dis	<input type="checkbox"/> 272.4 Hyperlipidemia	<input type="checkbox"/> 401.9 Hypertension	<input type="checkbox"/> 285.9 Anemia
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 626.3 Menstruation disord	<input type="checkbox"/> 780.9 Nonspeci signs & sym	<input type="checkbox"/> 300 Anxiety
<input type="checkbox"/> 716.0 Arthritis, nonspeci	<input type="checkbox"/> 627.2 Menopause	<input type="checkbox"/> 278.0 Obesity	<input type="checkbox"/> 716.0 Arthritis, nonspeci
<input type="checkbox"/> 414.0 ASHD	<input type="checkbox"/> 626.3 Menstruation disord	<input type="checkbox"/> 382.9 Otitis media	<input type="checkbox"/> 414.0 ASHD
<input type="checkbox"/> 493.9 Asthma	<input type="checkbox"/> 780.9 Nonspeci signs & sym	<input type="checkbox"/> 514.9 PID	<input type="checkbox"/> 493.9 Asthma
<input type="checkbox"/> 724.5 Back pain	<input type="checkbox"/> 650 Pregnancy, normal	<input type="checkbox"/> 461.9 Sinusitis	<input type="checkbox"/> 724.5 Back pain
<input type="checkbox"/> 490 Bronchitis, acute	<input type="checkbox"/> 461.9 Sinusitis	<input type="checkbox"/> 848.9 Sprain/strain/unspec.	<input type="checkbox"/> 490 Bronchitis, acute
<input type="checkbox"/> 682.9 Cellulitis	<input type="checkbox"/> 463 Tonsillitis, acute	<input type="checkbox"/> 465.9 Upper respir. inf.	<input type="checkbox"/> 682.9 Cellulitis
<input type="checkbox"/> 437.9 Cerebrovascular insul	<input type="checkbox"/> 599.0 Urinary tract inf.	<input type="checkbox"/> 616.10 Vaginitis	<input type="checkbox"/> 437.9 Cerebrovascular insul
<input type="checkbox"/> 786.50 Chest Pain	<input type="checkbox"/> 079.99 Viral infection	<input type="checkbox"/> 078.10 Warts, verruca	<input type="checkbox"/> 786.50 Chest Pain
<input type="checkbox"/> 372 Conjunctivitis			<input type="checkbox"/> 372 Conjunctivitis
<input type="checkbox"/> V25.09 Contraceptive adv			<input type="checkbox"/> V25.09 Contraceptive adv
<input type="checkbox"/> 924.9 Contusion, unspec			<input type="checkbox"/> 924.9 Contusion, unspec
<input type="checkbox"/> 496 COPD			<input type="checkbox"/> 496 COPD
<input type="checkbox"/> 311 Depression			<input type="checkbox"/> 311 Depression
<input type="checkbox"/> 692.9 Dermatitis, nonspeci			<input type="checkbox"/> 692.9 Dermatitis, nonspeci
<input type="checkbox"/> 250.0 Diabetes mellitus			<input type="checkbox"/> 250.0 Diabetes mellitus
<input type="checkbox"/> 780.4 Dizziness			<input type="checkbox"/> 780.4 Dizziness
<input type="checkbox"/> V70.0 Exam/ann: w/o sick			<input type="checkbox"/> V70.0 Exam/ann: w/o sick
<input type="checkbox"/> V20.2 Well child/baby			<input type="checkbox"/> V20.2 Well child/baby
<input type="checkbox"/> 780.7 Fatigue/malaise			<input type="checkbox"/> 780.7 Fatigue/malaise
<input type="checkbox"/> 829.0 Fract./unspec./clsd			<input type="checkbox"/> 829.0 Fract./unspec./clsd
DOCTOR: PLEASE CHECK () IF ANY SERVICES ARE RELATED TO:			
<input type="checkbox"/> E811 Auto Accident	<input type="checkbox"/> E849 On the job injury		
<input type="checkbox"/> E819 Motorcycle accident	<input type="checkbox"/> E368 Other party liable		
DIAGNOSIS(ES)			
I Knee injury			

Total Charges **50** Discount _____ Amount Paid **0**

David Rhodes, M.D.
 Physician Signature



PATIENT DISABILITY STATEMENT

Disabled _____ Partially Disabled _____

_____ thru _____

M D Y M D Y

OK to return to work _____

M D Y



QUIZ #20—ENCOUNTER FORM (#4 CATHY HARRISON)

Stewart Center for Women
1200 Carol Lane
Yourtown, Colorado 80000
(970) 555-1010

Clinton Fangman, M.D.
[X] Carolyn Hooper, M.D.
Scott Ludwig, M.D.

RETURN TO RECEPTIONIST

Account Number 1410 Appointment Date 4-2-XX

Patient information form including name (Harrison Cathy), date of birth (8-9-67), address (2419 Zendt Dr., Anytown CO 80000), insurance (GE540 02), and various medical service checkboxes with associated fees.

ICD-9 DIAGNOSIS table with columns for ICD-9, DIAGNOSIS, and checkboxes for various conditions such as PREGNANCY, BREAST, URINARY TRACT, and VAGINA.

FORM SB-1 (6/94)

Follow-up of 2/21/XX

Carolyn Hooper, M.D.



QUIZ #20—ENCOUNTER FORM (#5 ANDY CAVELLO)

SPRINGTOWN CLINIC 1824 PARK AVENUE SPRINGTOWN, CO 80002		Matthew Grimm, M.D. David Rhodes, M.D.		DATE OF SERVICE 07 / 19 / xx
Telephone (970) <input checked="" type="checkbox"/> 11 <input type="checkbox"/> 22 <input type="checkbox"/> 21 <input type="checkbox"/> 12 <input type="checkbox"/> 31 OFF OP IP HOME NH		NIGHT/SATURDAY CLINIC 99050 _____ AFTER HOURS SERVICE 99052 _____		PATIENT'S NAME (PLEASE PRINT) Andy Cavello
FACILITY NAME _____ OFFICE SERVICE Code Fee		SURGERY Code		INSURANCE COMPANY NAME EMPLOYER Blue Cross of CO Beaver Market
Brief 99201 9921 28 Limited 99202 99212 _____ Intern 99203 99213 _____ Extend 99204 99214 _____ Compre 99205 99215 _____		Casting _____ 29 _____ Plaster Cast Materials 99070 _____ Fiberglass Cast Materials 99070 _____ Circumcision, newborn 54150 _____ Cryotherapy 17340 _____ Ear Irrigation 69210 _____ Endometrial Biopsy 58100 _____ Electrosurgery 17 _____ location # _____		SUBSCRIBER NO. OR INSURED'S I.D. NO. GROUP NO 630-00-0099A BM630
Phone Call - Brief 99371 _____ Phone Call - Intermed. 99372 _____ Phone Call - Lengthy 99373 _____		Excision skin lesion 11 _____ location # _____ Incision & Drainage 10 _____ Inject Joint/Tendon 20 _____ Repair recent wound 12 _____ location size _____		SUBSCRIBER'S NAME RELATIONSHIP TO PATIENT Mark Parent
HOSPITAL SERVICE DT ADMIT ___/___/___ DT DIS ___/___/___		Remove corneal for body 65220 _____ Surgical Tray A4550 _____		SUBSCRIBER'S ADDRESS STREET CITY STATE ZIP CODE PATIENT'S SEX (M) F Check Patient's Relationship to Insured 1 Self 2 Spouse 3 Child <input checked="" type="checkbox"/> 4 Other
Intermediate 99222 _____ Comprehensive 99223 _____ Subsequent _____		DIAGNOSTIC PROCEDURES Audiometric testing 92552 _____ ECG w/int & report 93000 _____ ECG Interpret. Only 93010 _____ Flexible Sigmoidoscopy 45330 _____ Pulmonary Function 94160 _____		PATIENT'S BIRTHDATE DATE OF ACCIDENT OR ONSET PATIENT'S TELE NO. Mo. Day Year 1-15-97 7-19-xx 555-8812
Limit # @ 99231 _____ Inter # @ 99232 _____ Extend # @ 99233 _____		LABORATORY CBC 85022 _____ Chlamydia 87110 _____ Culture 870 _____ type _____		REQUIRED: CHECK "YES" OR "NO" AS APPLIES TO THESE SERVICES Work Related <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Caused By Another Party <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Patient Has Other Insurance <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Auto Accident <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Medicare Eligibility <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
WELL CHILD CARE Adolescent (12-17) 99394 _____ Late Childhood (5-11) 99393 _____ Early Childhood (1-4) 99392 _____ Infant (<1) 99391 _____		Hematocrit 85013 _____ Hemocult 82270 _____ Mono Spot 86308 _____ Pap Smear 88150 _____ Profiles 800 _____		IF YOU CHECKED "YES" TO ANY OF THE ABOVE PROVIDE THE FOLLOWING OTHER INSURANCE COVERAGE INSURED'S I.D. NO. Cigna 119001031
IMMUNIZATIONS AND INJECTIONS <input type="checkbox"/> DPT 90701 _____ <input type="checkbox"/> CPV 90712 _____ <input type="checkbox"/> DT 90702 _____ <input type="checkbox"/> Haemophilus B 90737 _____ <input type="checkbox"/> Hepatitis B 90731 _____ <input type="checkbox"/> PPD 86585 _____ <input type="checkbox"/> Influenza 90724 _____		Name _____ Protine 85610 _____ Rapid Strep 86403 _____ Sedrate 85651 _____ Urinalysis 81000 _____ Venipuncture 36415 _____ Wet Mount 87210 _____		I certify to the accuracy of the above patient information and authorize the release of any medical information necessary to process this claim. I request payment of insurance benefits to either myself or the provider listed below. Signed Mark Cavello Date 07/19/XX
OTHER SERVICES Allergy Shot 95120 _____		Code Fee		FAMILY PRACTICE — DIAGNOSTIC CODES: ICD-9-CM <input type="checkbox"/> 789.0 Abdominal Pain <input type="checkbox"/> 558.9 Gastroenteritis <input type="checkbox"/> 536.8 Acid peptic dis <input type="checkbox"/> 784.0 Headache <input type="checkbox"/> 477.9 Allergic Rhinitis <input type="checkbox"/> 272.4 Hyperlipidemia <input type="checkbox"/> 285.9 Anemia <input type="checkbox"/> 401.9 Hypertension <input type="checkbox"/> 300 Anxiety <input type="checkbox"/> V06.9 Immunizations <input type="checkbox"/> 716.0 Arthritis, nonspeci <input type="checkbox"/> 564.1 Irritable bowel synd <input type="checkbox"/> 414.0 ASHD <input type="checkbox"/> 879.8 Lacerat/wnd/external <input type="checkbox"/> 493.9 Asthma <input type="checkbox"/> 627.2 Menopause <input type="checkbox"/> 724.5 Back pain <input type="checkbox"/> 626.3 Menstruation disord <input type="checkbox"/> 490 Bronchitis, acute <input type="checkbox"/> 780.9 Nonspeci signs & sym <input type="checkbox"/> 682.9 Cellulitis <input type="checkbox"/> 278.0 Obesity <input type="checkbox"/> 437.9 Cerebrovascular insul <input type="checkbox"/> 382.9 Otitis media <input type="checkbox"/> 786.50 Chest Pain <input type="checkbox"/> 514.9 PID <input type="checkbox"/> 372 Conjunctivitis <input type="checkbox"/> 462 Pharyngitis, acute <input type="checkbox"/> V25.09 Contraceptive adv <input type="checkbox"/> 486 Pneumonia <input type="checkbox"/> 924.9 Contusion, unspec <input type="checkbox"/> 646.9 Pregnancy, complicated <input type="checkbox"/> 496 COPD <input type="checkbox"/> 650 Pregnancy, normal <input type="checkbox"/> 311 Depression <input type="checkbox"/> 461.9 Sinusitis <input type="checkbox"/> 692.9 Dermatitis, nonspeci <input type="checkbox"/> 848.9 Sprain/strain/unspec. <input type="checkbox"/> 250.0 Diabetes mellitus <input type="checkbox"/> 463 Tonsillitis, acute <input type="checkbox"/> 780.4 Dizziness <input type="checkbox"/> 465.9 Upper respir. inf. <input type="checkbox"/> V70.0 Exam/ann: w/o sick <input type="checkbox"/> 599.0 Urinary tract inf. <input type="checkbox"/> V20.2 Well child/baby <input type="checkbox"/> 616.10 Vaginitis <input type="checkbox"/> 780.7 Fatigue/malaise <input type="checkbox"/> 079.99 Viral infection <input type="checkbox"/> 829.0 Fract./unspec./clsd <input type="checkbox"/> 078.10 Warts, verruca
Total Charges 28 Discount _____ Amount Paid 0		DOCTOR: PLEASE CHECK () IF ANY SERVICES ARE RELATED TO: <input type="checkbox"/> E811 Auto Accident <input type="checkbox"/> E849 On the job injury <input type="checkbox"/> E819 Motorcycle accident <input type="checkbox"/> E368 Other party liable		DIAGNOSIS(ES) Foreign body, in digestive tract
Physician Signature Matthew Grimm, M.D.		PATIENT DISABILITY STATEMENT Disabled Partially Disabled _____ thru _____ M D Y M D Y OK to return to work _____ M D Y		()



QUIZ #20—ENCOUNTER FORM (#6 EMMA SMITH)

Patient Emma Smith Insured's Name _____
 Address 1410 Iris Dr. Insured's ID No. 501007319A
Mytown, Co 80001 Insurance Company Name Medicare
 Phone 970 555-5843 Employer _____
 Birthdate _____ Group No. _____
 Patient's Sex _____ Relationship to Insured _____
 Date of accident or onset of illness _____

Check all that apply to this visit: _____ Work related _____ Auto accident
 _____ Caused by another party _____ Other insurance _____ Medicare eligible

If you checked any of the above, please provide the following information:
 Insurance company _____ Insured's ID No. _____
 I certify to the accuracy of the above patient information and authorize the release of any medical information necessary to process this claim. I request payment of insurance benefits to either myself or to the provider listed below. Emma Smith

 11 Office _____ 12 Home _____ 21 IP _____ 22 OP _____ 31 NH
 _____ 99050 Night/Saturday Clinic _____ 99052 After Hours Service

	Code	Fee	Code	Fee
	New	Estab		
OFFICE SERVICE			SPECIAL PROCEDURES	
Brief	99201	99211	Casting	29405
Limited	99202	99212	Plaster cast materials	A4580
Intermediate	99203	99213	Fiberglass cast materials	A4590
Extended	99204	99214	Circumcision - Newborn	54150
Comprehensive	99205	99215	Cryotherapy	17340
			Ear piercing	69090
IMMUNIZATIONS AND INJECTIONS			Ear irrigation	69210
DTP		90701	Foreign body - Ear	69200
DTP & HIB		90720	Foreign body - Nose	30300
Hepatitis A		90730		
Hepatitis B		90731	LABORATORY	
Influenza virus		90724	Blood glucose	82948
MMR		90707	CBC	85022
OPV		90712	Hematocrit	85013
Gamma Globulin		90741	Occult blood	82270
Allergy shot		95120	Pap smear	88150
Antibiotic		90788	Rapid strep	86403
Injection		90782	Throat culture	87081
			Urinalysis	81000
WELL CHILD CARE			Urine culture	87086
Infant (<1)		99391	WBC	85048
Early childhood (1-4)		99392		
Late childhood 5-11)		99393	OTHER SERVICES	
Adolescent 12-17)		99394		
DIAGNOSIS	ICD-9-CM		Date of Service	<u>5-20-XX</u>
<u>dizziness</u>	_____		Today's charges	\$ <u>50.00</u>
_____	_____		Payments	<u>0</u>
_____	_____		Total due	<u>50.00</u>
MEDICAL CARE CENTER			_____ Dwight Harrison, M.D.	
100 South Main			<u>X</u> Leslie Jones, M.D.	
Yourtown, CO 80000			_____ Clifford Phillips, M.D.	
(970) 555-1111			_____ <i>Leslie Jones, M.D.</i>	
			Physician's Signature	



Completing the CMS-1500 Claim Form for Various Carriers

QUIZ #20—ENCOUNTER FORM (#7 SALLY SMITH)

Stewart Center for Women
1200 Carol Lane
Yourtown, Colorado 80000
(970) 555-1010

Clinton Fangman, M.D.
 Carolyn Hooper, M.D.
 Scott Ludwig, M.D.

RETURN TO RECEPTIONIST

Account Number 987 Appointment Date 04-01-XX

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Smith, Sally	2. PATIENT'S DATE OF BIRTH 11-26-60	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) Same
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) 1801 Peterson Ct. Springtown CO 80002	5. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	6. INSUREE'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS) BA1503
TELEPHONE NUMBER	7. INSURED'S GROUP NO. BA1503 <input checked="" type="checkbox"/> INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN (SIGNATURE ON FILE)	

OFFICE SERVICE FEE 60.00	THERAPEUTIC INJECTIONS	<input type="checkbox"/> 57454 * Colposcopy W/Biopsy
ESTAB NEW	<input type="checkbox"/> 90782 Therapeutic Injection	<input type="checkbox"/> 57452 Colposcopy w/o Biopsy
<input type="checkbox"/> 99211 <input type="checkbox"/> 99201 Level I	<input type="checkbox"/> 99070 Drug Mg	<input type="checkbox"/> 56420 Incision/Drainage Bartholin Cyst
<input type="checkbox"/> 99212 <input checked="" type="checkbox"/> 99202 Level II	<input type="checkbox"/> 99070 Drug Mg	<input type="checkbox"/> 57511 * Cryosurgery
<input type="checkbox"/> 99213 <input type="checkbox"/> 99203 Level III	LABORATORY	<input type="checkbox"/> 52000 Cystoscopy
<input type="checkbox"/> 99214 <input type="checkbox"/> 99204 Level IV	<input type="checkbox"/> 82948 Glucose Blood Stick	<input type="checkbox"/> 58120 D & C
<input type="checkbox"/> 99215 <input type="checkbox"/> 99205 Level V	<input type="checkbox"/> 85018 Hemoglobin	<input type="checkbox"/> 56501 * Destruction of lesion any Method (condylomata)
CONSULT 2ND OPIN	<input checked="" type="checkbox"/> 88150 Pap Smear 20.00	<input type="checkbox"/> 57170 Diaphragm Fitting
<input type="checkbox"/> 99241 <input type="checkbox"/> 99271 Level I	<input checked="" type="checkbox"/> 81025 * Pregnancy Test	<input type="checkbox"/> 57505 Endocervical Curettage
<input type="checkbox"/> 99242 <input type="checkbox"/> 99272 Level II	<input checked="" type="checkbox"/> 81002 UA-Dip Stick 10.00	<input type="checkbox"/> 58100 * Endometrial Biopsy/or Endocervical
<input type="checkbox"/> 99243 <input type="checkbox"/> 99273 Level III	<input type="checkbox"/> 87210 Wet Smear	<input type="checkbox"/> 58102 Endometrial Curettage (vabra)
<input type="checkbox"/> 99244 <input type="checkbox"/> 99274 Level IV	<input type="checkbox"/> 36415 Blood Draw	<input type="checkbox"/> 11200 * Excision Skin Tags to 15
<input type="checkbox"/> 99245 <input type="checkbox"/> 99275 Level V	<input type="checkbox"/> 88160 Breast Smear	<input type="checkbox"/> 58350 Hysteroscopy
ULTRASOUND	<input checked="" type="checkbox"/> TSH (thyroid stimulating hormone) 30.00	<input type="checkbox"/> 58300 * IUD Insertion
<input type="checkbox"/> 76856 GYN-Complete	PROCEDURES	<input type="checkbox"/> 58301 IUD Removed
<input type="checkbox"/> 76857 GYN-Limited (follicle)	<input type="checkbox"/> 58310 AID/AIH	<input type="checkbox"/> 59812 Suction Curettage
<input type="checkbox"/> 76830 Transvaginal	<input type="checkbox"/> 57500 * Biopsy of Cervix	
SUPPLIES	<input type="checkbox"/> 56605 * Biopsy of Vagina	
<input type="checkbox"/> 55670 Cath	<input type="checkbox"/> 56600 * Biopsy of Vulva	
<input type="checkbox"/> 39070 Cath Bag	<input type="checkbox"/> 19000 * Breast Aspiration	
<input type="checkbox"/> A4550 Surgical Tray	<input type="checkbox"/> 19100 * Breast Biopsy: Needle	
<input type="checkbox"/> 57160 * Pessary	<input type="checkbox"/> 19101 Breast: Excisional Biopsy	
		TODAY'S CHARGES 120.00
		AMOUNT PAID 120.00

ICD-9	DIAGNOSIS	ICD-9	DIAGNOSIS	ICD-9	DIAGNOSIS	ICD-9	DIAGNOSIS
<input type="checkbox"/>	PREGNANCY	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	VAGINA	<input type="checkbox"/>	HYPERSTROGENISM
<input type="checkbox"/>	V22 Pregnancy	<input type="checkbox"/>	716.9 Arthritis	<input type="checkbox"/>	627.3 Atrophic Vaginitis	<input type="checkbox"/>	256.0 Hypertestosteronism
<input type="checkbox"/>	V24 Pregnancy Test	<input type="checkbox"/>	724.5 Back Pain	<input type="checkbox"/>	612.1 Candida Vaginitis	<input type="checkbox"/>	256.1 Hypertestosteronism, Androgens
<input type="checkbox"/>	BREAST	<input type="checkbox"/>	692.9 Dermatitis	<input type="checkbox"/>	078.1 Condyloma	<input type="checkbox"/>	256.2 Ovarian Failure (ostabative)
<input type="checkbox"/>	610.0 Breast Cyst	<input type="checkbox"/>	780.4 Dizziness	<input type="checkbox"/>	623.0 Dysplasia	<input type="checkbox"/>	256.3 Primary Ovarian Failure
<input type="checkbox"/>	610.1 Breast Fibrocystic	<input type="checkbox"/>	558.9 Gastroenteritis Acute	<input type="checkbox"/>	623.5 Leukorrhea	<input type="checkbox"/>	256.4 Polycystic Ovaries
<input type="checkbox"/>	611.72 Breast Mass	<input type="checkbox"/>	784.0 Headache	<input type="checkbox"/>	616.10 Non Specific Vaginitis	<input type="checkbox"/>	256.8 Ovarian Dysfunction, Other
<input type="checkbox"/>	V76.1 Breast Screening	<input type="checkbox"/>	346.9 Headache-Migraine	<input type="checkbox"/>	131.01 Trichomonas Vaginitis	<input type="checkbox"/>	GENERAL GYN
<input type="checkbox"/>	611.6 Galactorrhea	<input type="checkbox"/>	307.81 Headache-Tension	<input type="checkbox"/>	623.2 Stenosis, Vaginal	<input type="checkbox"/>	626.0 Amenorrhea
<input type="checkbox"/>	675.24 Mastitis	<input type="checkbox"/>	401 Hypertension, essential	<input type="checkbox"/>	623.7 Polyp, Vagina	<input type="checkbox"/>	626.1 Oligomenorrhea
<input type="checkbox"/>	611.71 Mastodynia	<input type="checkbox"/>	701.9 Skin Tag	<input type="checkbox"/>	RECTUM / GI	<input type="checkbox"/>	626.3 Pubertal Menometrorrhagia
<input type="checkbox"/>	611.2 Fissure; Nipple	<input type="checkbox"/>	308.9 Stress Response	<input type="checkbox"/>	565.0 Anal Fissure	<input type="checkbox"/>	626.4 Irregular Menses
<input type="checkbox"/>	611.79 Discharge; Nipple	<input type="checkbox"/>	465.9 U.R.I.	<input type="checkbox"/>	569.42 Rectal Pain	<input type="checkbox"/>	626.6 Postcoital Bleeding
<input type="checkbox"/>	URINARY TRACT	<input type="checkbox"/>	542 Appendicitis (Non-acute)	<input type="checkbox"/>	455 Hemorrhoids	<input type="checkbox"/>	626.8 Dysfunctional Uterine Bleeding
<input type="checkbox"/>	595.0 Cystitis	<input type="checkbox"/>	307.41 Insomnia	<input type="checkbox"/>	564.0 Constipation	<input type="checkbox"/>	625.8 Dysmenorrhea
<input type="checkbox"/>	596.8 Dysssynergia	<input type="checkbox"/>	ENDOCRINE	<input type="checkbox"/>	564.1 Irritable Bowel Syndrome	<input type="checkbox"/>	617.9 Endometriosis
<input type="checkbox"/>	595.3 Trigonitis	<input type="checkbox"/>	244 Hypothyroidism	<input type="checkbox"/>	569.3 Rectal Bleeding	<input type="checkbox"/>	054.10 HSV
<input type="checkbox"/>	595.0 Acute Cystitis	<input type="checkbox"/>	242 Hyperthyroidism	<input type="checkbox"/>	569.0 Anal/Rectal Polyp	<input type="checkbox"/>	785.6 Lymphadenopathy
<input type="checkbox"/>	595.2 Chronic Cystitis	<input type="checkbox"/>	PELVIC RELAXATION	<input type="checkbox"/>	569.1 Rectal Prolapse	<input type="checkbox"/>	626.2 Menometrorrhagia/hypermenorrhea
<input type="checkbox"/>	597 Urethritis	<input type="checkbox"/>	618.0 Cystourethrocele/Rectocele	<input type="checkbox"/>	CERVIX	<input type="checkbox"/>	627.2 Menopause
<input type="checkbox"/>	599.0 UTI	<input type="checkbox"/>	618.6 Enterocoele	<input type="checkbox"/>	795.0 Abnormal Pap	<input type="checkbox"/>	626.9 Menstrual Disorders
<input type="checkbox"/>	599.3 Urethral Polyp	<input type="checkbox"/>	618.8 Pelvic Relaxation	<input type="checkbox"/>	233.1 Ca-in-Situ	<input type="checkbox"/>	625.2 Mittelschmerz
<input type="checkbox"/>	788.1 Dysuria	<input type="checkbox"/>	618.1 Uterine Prolapse	<input type="checkbox"/>	622.7 Cervical Polyp	<input type="checkbox"/>	625.9 Pelvic Pain
<input type="checkbox"/>	788.41 Frequency of urination	<input type="checkbox"/>	618.2 Uterovaginal Prolapse, incomplete	<input type="checkbox"/>	616.0 Cervicitis	<input type="checkbox"/>	614.9 P.I.D.
<input type="checkbox"/>	625.6 Stress Incontinence	<input type="checkbox"/>	618.5 Vaginal Vault Prolapse	<input type="checkbox"/>	078.1 Condyloma	<input type="checkbox"/>	625.4 P.M.S.
<input type="checkbox"/>	788.3 Urinary Incontinence	<input type="checkbox"/>	619 Fistula; Genital Tract	<input type="checkbox"/>	622.1 Dysplasia	<input type="checkbox"/>	627.1 Postmenopausal Bleeding
<input type="checkbox"/>	GENERAL MEDICAL	<input type="checkbox"/>	616.3 Bartholin Abscess	<input type="checkbox"/>	078.2 Pap Smear-Special Screening	<input type="checkbox"/>	V01.5 STD
<input type="checkbox"/>	787.01 Nausea w/Vomiting	<input type="checkbox"/>	616.2 Bartholin Cyst	<input type="checkbox"/>	622.0 Erosion, Cervix	<input checked="" type="checkbox"/>	V72.3 GYN Examination
<input type="checkbox"/>	787.02 Nausea Alone	<input type="checkbox"/>	233.3 Ca-in-Situ	<input type="checkbox"/>	622.4 Stenosis, Cervix	<input type="checkbox"/>	V25.9 Contraceptive Management
<input type="checkbox"/>	789.00 Abdominal Pain, Unspecified Site	<input type="checkbox"/>	078.1 Condyloma	<input type="checkbox"/>	UTERUS	<input type="checkbox"/>	V25.0 General Counseling/Advice
<input type="checkbox"/>	789.01 Right Upper Quadrant	<input type="checkbox"/>	692.9 Dermatitis	<input type="checkbox"/>	617.0 Adenomyosis	<input type="checkbox"/>	V25.01 Rx Contraceptive Pills
<input type="checkbox"/>	789.02 Left Upper Quadrant	<input type="checkbox"/>	623.0 Dysplasia	<input type="checkbox"/>	621.3 Endometrial Hyperplasia	<input type="checkbox"/>	V25.02 Diaphragm Fitting
<input type="checkbox"/>	789.04 Left Lower Quadrant	<input type="checkbox"/>	221.2 Lesion	<input type="checkbox"/>	615.9 Endometriosis	<input type="checkbox"/>	V25.1 IUD Insertion
<input type="checkbox"/>	789.30 Cr Lump, Unspecified Site	<input type="checkbox"/>	701.0 Lichen Sclerosus	<input type="checkbox"/>	218.9 Leiomyomata	<input type="checkbox"/>	V25.13 Implantable Subdermal Contraceptive
<input type="checkbox"/>	789.33 Right Lower Quadrant	<input type="checkbox"/>	706.2 Sebaceous Cyst	<input type="checkbox"/>	621.0 Poly; Uterine	<input type="checkbox"/>	NEOPLASMS, HISTORY OF
<input type="checkbox"/>	789.34 Left Lower Quadrant	<input type="checkbox"/>	624.0 Vulvar Dys trophy	<input type="checkbox"/>	621.2 Uterine Hypertrophy	<input type="checkbox"/>	V10.3 Breast
<input type="checkbox"/>	789.60 Abdominal Tenderness, Unspecified Site	<input type="checkbox"/>	625.0 Dyspareunia	<input type="checkbox"/>	621.5 Intrauterine Synechiae	<input type="checkbox"/>	V10.41 Cervix
<input type="checkbox"/>	789.63 Right Lower Quadrant	<input type="checkbox"/>	625.1 Vaginismus	<input type="checkbox"/>	OVARY	<input type="checkbox"/>	V10.43 Ovarian
<input type="checkbox"/>	789.64 Left Lower Quadrant	<input type="checkbox"/>	625.5 Pelvic Congestion	<input type="checkbox"/>	620.0 Follicular Cyst, Ovary	<input type="checkbox"/>	V10.42 Uterine
<input type="checkbox"/>	285.9 Anemia	<input type="checkbox"/>	456.6 Varices, Vulva	<input type="checkbox"/>	620.1 Corpus Luteum Cyst	<input type="checkbox"/>	V10.44 Vulva/Vagina
				<input type="checkbox"/>	620.2 Ovarian Cyst	<input type="checkbox"/>	V50.42 Prophylactic Ovary Removal
						<input type="checkbox"/>	SUPPLEMENTARY HEALTH SERVICES
						<input type="checkbox"/>	ICD-9

FORM SB-1 (6/94)

Clinton Fangman, M.D.



QUIZ #20—ENCOUNTER FORM (#8 ROCKY SANCHEZ)

**Dr. Sarah Duncan
1414 Swallow Street
Yourtown, Co. 80000**

						Date of Service:			
		10		10		XX			
Acct. #		Patient name:			Responsible party:				
2210		Rocky Sanchez			Same				
	Description	CPT	Fee	Description	CPT	Fee	Description	CPT	Fee
	Office or other outpatient service			Therapy			X-ray		
	New patient level 1	99201		Exercises	97110		Cervical spine	72040	
	New patient level 2	99202		Gait Training	97116		T-spine	72070	
	New patient level 3	99203					Lumbar spine	72100	
X	New patient level 4	99204	\$80.00	Casts			Scoliosis	72090	
	New patient level 5	99205		Long Arm	29065		Pelvis	72170	
	Established Patient			Short Arm	29075		Hip	73510	
	Est. patient level 1	99211		LA splint	29105		Clavicle	73000	
	Est. patient level 2	99212		SA splint	29125		Shoulder	73030	
	Est. patient level 3	99213		Long leg	29345		Humerus	73060	
	Est. patient level 4	99214		Short leg	29405		Elbow	73070	
	Est. patient level 5	99215		Walking	29425		Wrist	73100	
	Emergency department			PTB	29435		Hand	73120	
	New or est. level 1	99281		Cylinder	29365		Finger	73140	
	New or est. level 2	99282		Leg splint	29515		Femur	73550	
	New or est. level 3	99283		Cast removal-leg	29700		Knee	73560	
	New or est. level 4	99284		Cast removal-arm	29705		Leg	73590	
	New or est. level 5	99285		X Cervical collar	99070	\$45.00	Ankle	73610	

ICD-9-CM DIAGNOSTIC CODES

Ankle sprain	845.00	Forearm Fx	813.83	Lumbar hernia disk	722.1
Ankle Fx	824.8	Ganglion	727.43	Lumbar sprain	846.0
Arm Fx	812.20	Carpal Tunnel	354.0	Lumbar Fx	805.8
Elbow sprain	841.9	Hand Fx	815.00	X Neck Sprain	847.0
Elbow Fx	812.40	Wrist Fx	814.00	Neck hernia disk	722.0
Femur Fx	820	Hip Fx	820	Osteomyelitis	730
Finger sprain	842.13	Hip Deg	715.95	Pelvis Fx	808.59
Finger Fx	816.00	Knee Deg	715.96	Scoliosis congenital	754.2
Foot Fx	825.25	Knee sprain	844.9	Shoulder dislocation	831.01

Surgery:

Hospital:

Diagnosis:

ICD-9-CM code:

Physician's signature: *Sarah Duncan M.D.*

Previous Balance	\$
Today's Charge	\$ 125.00
Cash	\$
Check	\$
Current Balance	\$ 125.00

I authorize the release of any information including diagnosis and treatment. I authorize my insurance carrier to pay directly to the doctor any benefits otherwise payable to me.

Rocky Sanchez

Signature of patient (or parent of minor child)



QUIZ #20—ENCOUNTER FORM (#9 PAULA HIGGINS)

Patient <u>Paula Higgins</u> Address <u>2159 Wyndote St.</u> <u>Yourtown, CO 80000</u> Phone _____ Patient's Birthdate <u>10-18-76</u> Patient's Sex <u>F</u> Date of accident or onset of illness _____ Check all that apply to this visit: _____ Work related _____ Auto accident _____ Caused by another party _____ Other insurance _____ Medicare eligible If you checked any of the above, please provide the following information: Insurance company _____ Insured's ID No _____ I certify to the accuracy of the above patient information and authorize the release of any medical information necessary to process this claim. I request payment of insurance benefits to either myself or to the provider listed below. <u>Paula Higgins</u>	Insured's Name _____ Insured's ID No _____ Insurance Company Name _____ Employer _____ Group No _____ Relationship to Insured _____																																																																																																																																																																		
X <u>11</u> Office _____ 12 Home _____ 21 IP _____ 22 OP _____ 31 NH _____ _____ 99050 Night/Saturday Clinic _____ 99052 After Hours Service _____																																																																																																																																																																			
<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Code</th> <th style="text-align: center;">Fee</th> </tr> <tr> <th></th> <th style="text-align: center;">New</th> <th style="text-align: center;">Estab</th> </tr> </thead> <tbody> <tr> <td colspan="3">OFFICE SERVICE</td> </tr> <tr> <td>Brief</td> <td style="text-align: center;">99201</td> <td style="text-align: center;">(99211) 30</td> </tr> <tr> <td>Limited</td> <td style="text-align: center;">99202</td> <td style="text-align: center;">99212 _____</td> </tr> <tr> <td>Intermediate</td> <td style="text-align: center;">99203</td> <td style="text-align: center;">99213 _____</td> </tr> <tr> <td>Extended</td> <td style="text-align: center;">99204</td> <td style="text-align: center;">99214 _____</td> </tr> <tr> <td>Comprehensive</td> <td style="text-align: center;">99205</td> <td style="text-align: center;">99215 _____</td> </tr> <tr> <td colspan="3">IMMUNIZATIONS AND INJECTIONS</td> </tr> <tr> <td>DTP</td> <td style="text-align: center;">90701</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>DTP & HIB</td> <td style="text-align: center;">90720</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Hepatitis A</td> <td style="text-align: center;">90730</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Hepatitis B</td> <td style="text-align: center;">90731</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Influenza virus</td> <td style="text-align: center;">90724</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>MMR</td> <td style="text-align: center;">90707</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>OPV</td> <td style="text-align: center;">90712</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Gamma Globulin</td> <td style="text-align: center;">90741</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Allergy shot</td> <td style="text-align: center;">(95120)</td> <td style="text-align: center;">10</td> </tr> <tr> <td>Antibiotic</td> <td style="text-align: center;">90788</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Injection</td> <td style="text-align: center;">90782</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="3">WELL CHILD CARE</td> </tr> <tr> <td>Infant (<1)</td> <td style="text-align: center;">99391</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Early childhood (1-4)</td> <td style="text-align: center;">99392</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Late childhood 5-11)</td> <td style="text-align: center;">99393</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Adolescent 12-17)</td> <td style="text-align: center;">99394</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="3">DIAGNOSIS</td> </tr> <tr> <td style="text-align: right;">ICD-9-CM</td> <td colspan="2"></td> </tr> <tr> <td style="text-align: right;"><u>Allergic rhinitis</u></td> <td style="text-align: center;"><u>477.9</u></td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Code	Fee		New	Estab	OFFICE SERVICE			Brief	99201	(99211) 30	Limited	99202	99212 _____	Intermediate	99203	99213 _____	Extended	99204	99214 _____	Comprehensive	99205	99215 _____	IMMUNIZATIONS AND INJECTIONS			DTP	90701	_____	DTP & HIB	90720	_____	Hepatitis A	90730	_____	Hepatitis B	90731	_____	Influenza virus	90724	_____	MMR	90707	_____	OPV	90712	_____	Gamma Globulin	90741	_____	Allergy shot	(95120)	10	Antibiotic	90788	_____	Injection	90782	_____	WELL CHILD CARE			Infant (<1)	99391	_____	Early childhood (1-4)	99392	_____	Late childhood 5-11)	99393	_____	Adolescent 12-17)	99394	_____	DIAGNOSIS			ICD-9-CM			<u>Allergic rhinitis</u>	<u>477.9</u>	_____	<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">Code</th> <th style="text-align: center;">Fee</th> </tr> <tr> <th></th> <th style="text-align: center;">New</th> <th style="text-align: center;">Estab</th> </tr> </thead> <tbody> <tr> <td colspan="3">SPECIAL PROCEDURES</td> </tr> <tr> <td>Casting</td> <td style="text-align: center;">29</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Plaster cast materials</td> <td style="text-align: center;">A4580</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Fiberglass cast materials</td> <td style="text-align: center;">A4590</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Circumcision - Newborn</td> <td style="text-align: center;">54150</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Cryotherapy</td> <td style="text-align: center;">17340</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Ear piercing</td> <td style="text-align: center;">69090</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Ear irrigation</td> <td style="text-align: center;">69210</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Foreign body - Ear</td> <td style="text-align: center;">69200</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Foreign body - Nose</td> <td style="text-align: center;">30300</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="3">LABORATORY</td> </tr> <tr> <td>Blood glucose</td> <td style="text-align: center;">82948</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>CBC</td> <td style="text-align: center;">85022</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Hematocrit</td> <td style="text-align: center;">85013</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Occult blood</td> <td style="text-align: center;">82270</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Pap smear</td> <td style="text-align: center;">88150</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Rapid strep</td> <td style="text-align: center;">86403</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Throat culture</td> <td style="text-align: center;">87081</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Urinalysis</td> <td style="text-align: center;">81000</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Urine culture</td> <td style="text-align: center;">87086</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>WBC</td> <td style="text-align: center;">85048</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="3">OTHER SERVICES</td> </tr> <tr> <td colspan="3">_____</td> </tr> <tr> <td colspan="3">_____</td> </tr> </tbody> </table>		Code	Fee		New	Estab	SPECIAL PROCEDURES			Casting	29	_____	Plaster cast materials	A4580	_____	Fiberglass cast materials	A4590	_____	Circumcision - Newborn	54150	_____	Cryotherapy	17340	_____	Ear piercing	69090	_____	Ear irrigation	69210	_____	Foreign body - Ear	69200	_____	Foreign body - Nose	30300	_____	LABORATORY			Blood glucose	82948	_____	CBC	85022	_____	Hematocrit	85013	_____	Occult blood	82270	_____	Pap smear	88150	_____	Rapid strep	86403	_____	Throat culture	87081	_____	Urinalysis	81000	_____	Urine culture	87086	_____	WBC	85048	_____	OTHER SERVICES			_____			_____		
	Code	Fee																																																																																																																																																																	
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OFFICE SERVICE																																																																																																																																																																			
Brief	99201	(99211) 30																																																																																																																																																																	
Limited	99202	99212 _____																																																																																																																																																																	
Intermediate	99203	99213 _____																																																																																																																																																																	
Extended	99204	99214 _____																																																																																																																																																																	
Comprehensive	99205	99215 _____																																																																																																																																																																	
IMMUNIZATIONS AND INJECTIONS																																																																																																																																																																			
DTP	90701	_____																																																																																																																																																																	
DTP & HIB	90720	_____																																																																																																																																																																	
Hepatitis A	90730	_____																																																																																																																																																																	
Hepatitis B	90731	_____																																																																																																																																																																	
Influenza virus	90724	_____																																																																																																																																																																	
MMR	90707	_____																																																																																																																																																																	
OPV	90712	_____																																																																																																																																																																	
Gamma Globulin	90741	_____																																																																																																																																																																	
Allergy shot	(95120)	10																																																																																																																																																																	
Antibiotic	90788	_____																																																																																																																																																																	
Injection	90782	_____																																																																																																																																																																	
WELL CHILD CARE																																																																																																																																																																			
Infant (<1)	99391	_____																																																																																																																																																																	
Early childhood (1-4)	99392	_____																																																																																																																																																																	
Late childhood 5-11)	99393	_____																																																																																																																																																																	
Adolescent 12-17)	99394	_____																																																																																																																																																																	
DIAGNOSIS																																																																																																																																																																			
ICD-9-CM																																																																																																																																																																			
<u>Allergic rhinitis</u>	<u>477.9</u>	_____																																																																																																																																																																	
	Code	Fee																																																																																																																																																																	
	New	Estab																																																																																																																																																																	
SPECIAL PROCEDURES																																																																																																																																																																			
Casting	29	_____																																																																																																																																																																	
Plaster cast materials	A4580	_____																																																																																																																																																																	
Fiberglass cast materials	A4590	_____																																																																																																																																																																	
Circumcision - Newborn	54150	_____																																																																																																																																																																	
Cryotherapy	17340	_____																																																																																																																																																																	
Ear piercing	69090	_____																																																																																																																																																																	
Ear irrigation	69210	_____																																																																																																																																																																	
Foreign body - Ear	69200	_____																																																																																																																																																																	
Foreign body - Nose	30300	_____																																																																																																																																																																	
LABORATORY																																																																																																																																																																			
Blood glucose	82948	_____																																																																																																																																																																	
CBC	85022	_____																																																																																																																																																																	
Hematocrit	85013	_____																																																																																																																																																																	
Occult blood	82270	_____																																																																																																																																																																	
Pap smear	88150	_____																																																																																																																																																																	
Rapid strep	86403	_____																																																																																																																																																																	
Throat culture	87081	_____																																																																																																																																																																	
Urinalysis	81000	_____																																																																																																																																																																	
Urine culture	87086	_____																																																																																																																																																																	
WBC	85048	_____																																																																																																																																																																	
OTHER SERVICES																																																																																																																																																																			

<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Medical Care Center</td> <td style="width: 50%;">Date of Service <u>12-20-XX</u></td> </tr> <tr> <td>100 South Main</td> <td>Today's charges <u>\$ 40.00</u></td> </tr> <tr> <td>Yourtown, CO 80000</td> <td>Payments <u>10.00</u></td> </tr> <tr> <td>(970) 555-1111</td> <td>Total due <u>30.00</u></td> </tr> </table>		Medical Care Center	Date of Service <u>12-20-XX</u>	100 South Main	Today's charges <u>\$ 40.00</u>	Yourtown, CO 80000	Payments <u>10.00</u>	(970) 555-1111	Total due <u>30.00</u>																																																																																																																																																										
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QUIZ #20—ENCOUNTER FORM (#10 BRENTON NILES)

Patient Brenton Niles Insured's Name Gary Niles
 Address 2777 Lincoln Ave Insured's ID No 300-00-0848
Youngstown, CO 80004 Insurance Company Name Net Life
 Phone 970-555-9111 Employer Western Bell
 Patient's Birthdate 4-15-00 Group No 629
 Patient's Sex male Relationship to Insured Child
 Date of accident or onset of illness _____
 Check all that apply to this visit: _____ Work related _____ Auto accident
 _____ Caused by another party _____ Other insurance _____ Medicare eligible
 If you checked any of the above, please provide the following information:
 Insurance company _____ Insured's ID No _____
 I certify to the accuracy of the above patient information and authorize the release of any medical information necessary to process
 this claim. I request payment of insurance benefits to either myself or to the provider listed below. Gary Niles

11 Office _____ 12 Home _____ 21 IP _____ 22 OP _____ 31 NH _____
 _____ 99050 Night/Saturday Clinic _____ 99052 After Hours Service

	Code		Fee	Code		Fee
	New	Estab		New	Estab	
OFFICE SERVICE						
Brief	99201	<u>99211</u>	<u>40</u>			
Limited	99202	99212	___			
Intermediate	99203	99213	___			
Extended	99204	99214	___			
Comprehensive	99205	99215	___			
IMMUNIZATIONS AND INJECTIONS						
DTP		90701	___			
DTP & HIB		90720	___			
Hepatitis A		90730	___			
Hepatitis B		90731	___			
Influenza virus		90724	<u>17</u>			
MMR		90707	___			
OPV		90712	___			
Gamma Globulin		90741	___			
Allergy shot		95120	___			
Antibiotic		90788	___			
Injection		90782	___			
WELL CHILD CARE						
Infant (<1)		99391	___			
Early childhood (1-4)		99392	___			
Late childhood 5-11)		99393	___			
Adolescent 12-17)		99394	___			
DIAGNOSIS		ICD-9-CM				
<u>immunizations</u>		<u>V04.81</u>				
_____		_____				
_____		_____				
SPRINGTOWN CLINIC						
1824 Park Ave.						
Springtown, CO 80002						
SPECIAL PROCEDURES						
Casting		29	___			
Plaster cast materials		A4580	___			
Fiberglass cast materials		A4590	___			
Circumcision - Newborn		54150	___			
Cryotherapy		17340	___			
Ear piercing		69090	___			
Ear irrigation		69210	___			
Foreign body - Ear		69200	___			
Foreign body - Nose		30300	___			
LABORATORY						
Blood glucose		82948	___			
CBC		85022	___			
Hematocrit		85013	___			
Occult blood		82270	___			
Pap smear		88150	___			
Rapid strep		86403	___			
Throat culture		87081	___			
Urinalysis		81000	___			
Urine culture		87086	___			
WBC		85048	___			
OTHER SERVICES						
Immunization Admin.		90471	\$20			
Date of Service		<u>5-9-XX</u>				
Today's charges		\$	<u>77</u>			
Payments			<u>10</u>			
Total due			<u>67</u>			
<input checked="" type="checkbox"/> <u>David Rhodes, M.D.</u>						
_____ <u>Matthew Grimm, M.D.</u>						
<u>David Rhodes, M.D.</u>						
Physician's Signature						