Fred Grover Jr. M.D.
360 S. Monroe St., Suite 310
Denver, Co. 80209

Steps for submitting a superbill to insurance for reimbursement back to you.

Attached is a copy of a CMS 1500 form example and an example of a diagnosis/visit summary that my system prints up for you at the end of the visit. I've done my best to present the best way to submit this to insurance. Since you are getting reimbursed for visit, you will be putting your name in the billing provider field, otherwise they will send me a check which will create delays and headaches.

Process is to fill out 1500 form or similar from your plan, attach copy of my charge capture form, and copy of your insurance card. Then mail in to your insurance plan.

I've provided this information to help you succeed in getting reimbursement for your visit with me. I cannot provide additional billing support other than giving you the codes and receipt from visit. I no longer have an insurance billing assistant, and no longer process insurance. The process for me to deal with insurance in past was extremely time consuming and expensive, hence my decision to opt out of all insurance plans. I would lose approximately 50 grand a year from unreimbursed visits, which I could not write-off at end of year. Simple things like doing a pap smear one day prior to a year since last one would result in no reimbursement to me for visit. I could go on for days with other examples....

Your health plan should be able to assist you in filling out their particular form if needed, and guide you on corrections if needed.

If you have any tips that you learn while processing your claims and want to pass them on to others, please let me know and I'll be glad to post on our website.

You will note that processing claims is often a lesson in futility. When I used to take insurance I would send in a clean claim electronically and frequently it would get rejected. I'd resubmit a second time exactly the same and it would be accepted. It is well known that insurance companies will reject perfect claims knowing that providers or patients will give up and not re-submit. Hence they win/we lose. Keep this in mind. Once again a HSA with catastrophic will give you more control of your health care dollar, and keep it out of the hands of Health Plan stockholders.

Thank you,

Fred Grover Jr. M.D

Phone 888-726-4442/Fax 303-537-5639
RevolutionaryMD.com

— This is form that prints out from my electronic medical records system at end of visit. Some plans will accept this form without use of CMS 1500 or similar - you can use this for HSA 400 / FLEX

Mouse, Mickey 03/20/1962
Office/Outpatient Visit
Visit Date: Sun, Nov 28, 2010 07:07 pm
Provider: Fred Grover Jr, MD
Location: Fred Grover Jr. M.D.

Electronically signed by Fred Grover Jr, MD on 11/28/2010 07:08:06 PM
Account #: MOUMIC0001

CHARGE CAPTURE:

Primary Diagnosis:
401.1 Essential hypertension

Orders:
99215 Office/outpatient visit; established patient, level 5

272.4 Hyperlipidemia

530.81 GERD

★ → **Patient Paid Provider in Full**
Reimburse Patient Please
Fred Grover Jr. M.D.
Tax ID: 20-2951106

Paid $175

Fred Grover MD

— Attach this to CMS 1500 or your health plan form & copy of your insurance card. They should send check to you not me.

you may need to use this form or similar one from health plan to get reimbursement. A blank form is also available on our site.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☒ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123 456 78

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

3. PATIENT'S BIRTH DATE: 04 02 28 SEX: M ☒ F ☐

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

5. PATIENT'S ADDRESS (No., Street): 245 Walt Disney Drive

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

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

CITY: Anaheim STATE: CA

8. PATIENT STATUS: Single ☒ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 92802 TELEPHONE (Include Area Code): (619) 758-1111

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: D 123 456

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

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

a. INSURED'S DATE OF BIRTH: 04 02 28 SEX: M ☒ F ☐

b. OTHER INSURED'S DATE OF BIRTH: 4 2 1928 SEX: M ☒ F ☐

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

b. EMPLOYER'S NAME OR SCHOOL NAME: SAME

c. EMPLOYER'S NAME OR SCHOOL NAME: Disney Studios

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: SAME

d. INSURANCE PLAN NAME OR PROGRAM NAME: Disney Health

10d. RESERVED FOR LOCAL USE

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

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: Mickey Mouse DATE: 11/28/10

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: Mickey Mouse

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 TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Fred Grover Jr. MD

17a.

17b. NPI 1346285228

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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. 401.1
2. 272.4
3. 530.78
4.

Diagnosis Codes ICD-9

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: N/A

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 11 28 10	11 28 10			99215			$175.00	1		NPI	1346285228
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Visit code or procedure Code

Mickey's SSN

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 111-11-1111 SSN ☒ EIN ☐

26. PATIENT'S ACCOUNT NO.: N/A

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

28. TOTAL CHARGE: $ 175.00

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.)

Mickey Mouse 11/28/10

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Fred Grover Jr. MD.
360 S. Monroe St., Suite 310
Denver, Co. 80209

a. 1346285228 b.

33. BILLING PROVIDER INFO & PH # (619) 758-1111

Mickey Mouse
245 Walt Disney Drive
Anaheim, CA 92802

a. b.

NUCC Instruction Manual available at: www.nucc.org

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

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

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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.

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 _____

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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

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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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	

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.

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