

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

Eyeglass Lenses Examples: CMS-1500

Examples in this section will help providers bill for eyeglass lenses on the *CMS-1500* claim form. Refer to the *Eyeglass Lenses* section of this manual for policy information. Refer to the *CMS-1500 Completion for Vision Care* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts, or dollar signs with the charges. When entering modifiers, do not include hyphens. If requested information does not fit neatly in the *Reserved for Local Use* area (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Single Vision Lenses in Lieu of Bifocals

Figure 1. Single vision lenses in lieu of bifocals.

This is a sample only. Please adapt to your billing situation.

In this example, an optometrist who resides in a Prison Industry Authority (PIA) county is billing for two pairs of single vision eyeglasses – one for distance vision and one for near vision – in lieu of bifocals, for a recipient who cannot adapt to bifocals.

Enter “11” in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. Primary ICD-9-CM code 367.4 (presbyopia) and secondary ICD-9-CM code 368.10 (subjective visual disturbances) are entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

Note: Prescribing two pairs of eyeglasses in lieu of bifocals for recipients 38 years of age or older is one of the conditions that requires valid ICD-9-CM diagnosis codes to be billed on the claim. Refer to the *Eye Appliances, Eyeglass Frames and Eyeglass Lenses* sections in this manual for policy and billing instructions.

Because two frames are required for a recipient who has no prior frame, HCPCS code V2020 (frames, purchases) is billed with modifier NU (new equipment) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity “2” in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA county (Sacramento in this example), only lens dispensing fees (CPT-4 codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT-4 code 92340 (fitting of spectacles, except for aphakia; monofocal) is billed. Modifier NU is billed because the recipient has no prior history of ophthalmic lenses. Enter “4” in the *Days or Units* field (Box 24G) to indicate that four monofocal or single vision lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

The long term care facility’s name and National Provider Identifier (NPI) are entered in the *Name of Referring Provider or Other Source* (Box 17) and *NPI* (Box 17b) fields to indicate that the recipient meets the Optional Benefits Exclusion exemption. This information is required on the claim for the reimbursement of HCPCS code V2020 and CPT-4 code 92340. Refer to the *Optional Benefits Exclusion* section in this manual for additional information.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER 1a. INSURED'S I.D. NUMBER (For Program in Item 1) **90000000A95001**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **DOE JOHN** 3. PATIENT'S BIRTH DATE (MM | DD | YY) **06 | 21 | 62** SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) **1234 MAIN STREET** 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY **SACRAMENTO** STATE **CA** 8. PATIENT STATUS Single Married Other CITY STATE

ZIP CODE **95823** TELEPHONE (Include Area Code) **(916) 555-5555** 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: Employed Full-Time Part-Time Student ZIP CODE TELEPHONE (Include Area Code) ()

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? YES NO PLACE (State) c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH (MM | DD | YY) SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME

b. OTHER INSURED'S DATE OF BIRTH (MM | DD | YY) SEX M F c. INSURANCE PLAN NAME OR PROGRAM NAME

c. EMPLOYER'S NAME OR SCHOOL NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **If yes, return to and complete item 9 a-d.**

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM | DD | YY) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM | DD | YY) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM | DD | YY) TO (MM | DD | YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI **NPI** 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM | DD | YY) 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. **3674** 3. 2. **36810** 4. 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	A. DATE(S) OF SERVICE			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. #
	From	To	YY									
1	08	20	08	11		V2020 NU		5000	2		NPI	
2	08	20	08	11		92340 NU		10000	4		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

24. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO 28. TOTAL CHARGE \$ **15000** 29. AMOUNT PAID \$ 30. BALANCE DUE \$ **15000**

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.) **Jane Doe** 32. SERVICE FACILITY LOCATION INFORMATION a. **NPI** b. 33. BILLING PROVIDER INFO & PH # **(916) 555-5555**
JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555
a. **0123456789** b.

SIGNED _____ DATE **08/20/08**

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Figure 1. Single Vision Lenses in Lieu of Bifocals for a Recipient 38 Years or Older on the Date of Service.

Bifocals Prescribed for Recipients Younger Than 38 Years of Age

Figure 2. Bifocals prescribed for recipients younger than 38 years of age on the date of service.

This is a sample only. Please adapt to your billing situation.

In this example, an optometrist, who resides in a PIA county, has prescribed bifocal lenses for a 10-year old child.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. Primary ICD-9-CM code 367.51 (paresis of accommodation) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

Note: Prescribing multifocal for recipients younger than 38 years of age on the date of service is one of the conditions that require specified ICD-9-CM diagnosis codes to be billed as a primary diagnosis on the claim. Refer to the *Eye Appliances, Eyeglass Frames and Eyeglass Lenses* sections in this manual for policy and billing instructions.

Because one frame is required for a recipient who has none prior, HCPCS code V2020 (frames, purchases) is billed with modifier NU (new equipment) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity "1" in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA county (Sacramento in this example), only lens dispensing fees (CPT-4 codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT-4 code 92341 (fitting of spectacles, except for aphakia; bifocal) is billed. Modifier NU is billed since the recipient has no prior history of ophthalmic lenses. Enter "2" in the *Days or Units* field (Box 24G) to indicate that two bifocal lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim.

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> <h2 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h2> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>											
PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9000000A95001					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN						3. PATIENT'S BIRTH DATE MM DD YY SEX 06 21 82 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY SACRAMENTO			STATE CA			7. INSURED'S ADDRESS (No., Street)			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
ZIP CODE 95823			TELEPHONE (Include Area Code) (916) 555-5555			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		
9a. OTHER INSURED'S POLICY OR GROUP NUMBER						11. INSURED'S POLICY GROUP OR FECA NUMBER					
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						11a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
9c. EMPLOYER'S NAME OR SCHOOL NAME						11b. EMPLOYER'S NAME OR SCHOOL NAME					
9d. INSURANCE PLAN NAME OR PROGRAM NAME						11c. INSURANCE PLAN NAME OR PROGRAM NAME					
10a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
10b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____						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 _____					
10c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						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 _____					
12. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.						14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 08 20 08					
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 15a. _____ 15b. _____						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY FROM _____ TO _____					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM _____ TO _____					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 36751 3. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSPOT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #						23. PRIOR AUTHORIZATION NUMBER					
1 08 20 08 11 V2020 NU 5000 1 NPI						25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					
2 08 20 08 11 92341 NU 1000 2 NPI						26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If or gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					
3 _____ NPI						28. TOTAL CHARGE \$ 15000 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 15000					
4 _____ NPI						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.) <i>Jane Doe</i>					
5 _____ NPI						32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.					
6 _____ NPI						33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.					
SIGNED _____ DATE 08/20/08											
NUCC Instruction Manual available at: www.nucc.org						APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)					

Figure 2. Bifocals Prescribed for Recipients Younger Than 38 Years of Age on the Date of Service.

**Eyeglass Replacement:
Previous Lenses Less
Than Two Years Old**

Figure 3. Eyeglass replacement: Previous eyeglasses are less than two years old.

This is a sample only. Please adapt to your billing situation.

In this example, an optometrist, who resides in a PIA county, is billing for a replacement pair of bifocal eyeglasses. Previous eyeglasses, that were ordered less than two years ago, are lost. The optometrist has obtained a signed statement from the recipient about the circumstances for replacement to keep in the medical record.

Enter "11" in the *Place of Service* field (Box 24B) to indicate that service was rendered in an office. Primary ICD-9-CM code 367.4 (Presbyopia) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21). Enter secondary diagnosis code(s), if applicable, on lines 2, 3 and 4 of Box 21.

Because one replacement frame is required for the recipient, HCPCS code V2020 (frames, purchases) is billed with modifier RA (replacement) in the *Procedures, Services, or Supplies* field (Box 24D) and quantity "1" in the *Days or Units* field (Box 24G) of the claim. Enter the usual and customary charges in the *Charges* field (Box 24F).

In addition, because the recipient resides in a PIA County (Sacramento in this example), only lens dispensing fees (CPT-4 codes 92340 – 92342 and 92352 – 92353) can be billed. Therefore, CPT-4 code 92341 (fitting of spectacles, except for aphakia; bifocal) is billed. Modifier RA is billed to indicate that the optometrist is replacing the lenses for the recipient. Enter "2" in the *Days or Units* field (Box 24G) to indicate that two bifocal lenses are being dispensed. Enter the usual and customary charges in the *Charges* field (Box 24F).

Refer to the *CMS-1500 Completion for Vision Care* section in this manual for instructions to complete remaining fields on the claim.

Refer to the *Eye Appliances, Eyeglass Frames and Eyeglass Lenses* sections in this manual for policy and billing instructions.

<div style="border: 1px solid black; border-radius: 10px; padding: 2px 10px; display: inline-block;">1500</div> <h2 style="margin: 0;">HEALTH INSURANCE CLAIM FORM</h2> <p style="font-size: small; margin: 0;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>												
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>												
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9000000A95001						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JOHN				3. PATIENT'S BIRTH DATE MM DD YY 06 21 62		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)						
CITY SACRAMENTO			STATE CA			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE		
ZIP CODE 95823		TELEPHONE (Include Area Code) (916) 555-5555				ZIP CODE		TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)						
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE												
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3674						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
2. _____						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. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID #						
1 09 20 09		11		V2020		RA		5000		1		
2 09 20 09		11		92341		RA		10000		2		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (If gov't claims, see 0390) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ 15000		29. AMOUNT PAID \$	
									30. BALANCE DUE \$ 15000			
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.) <i>Jane Doe</i>						32. SERVICE FACILITY LOCATION INFORMATION a. NPI			33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555			
SIGNED _____ DATE 09/30/09						b.			a. 0123456789		b.	

Figure 3. Eyeglass Replacement: Previous Eyeglasses are Less Than Two Years Old.