SECTION IV: Services and Supplies To Be Considered For Reimbursement

These may include ambulance services, medical appliances, diabetic supplies, glasses and/or contact lenses or out-of-network services. **Your health insurance company requires that procedure codes and diagnosis codes be supplied by the providers of the service. Claims or itemized receipts received without the information below will be RETURNED.**

Please indicate where services were rendered if not in North Carolina: **ENTER OFFICE NAME**

Country: Currency Used:

Date of Service (MM-DD-YY)	Procedure Codes and Description of Service/Supplies	Diagnosis Codes and Symptoms you sought treatment for	Charge
01-05-18	EXAMPLE: 99201 Office or other outpatient visit for New Patient	J09 Influenza	110.00
Procedure Date	**MAC Anesthesia**	**00921QX-P1**	
	Anesthesia Time	**60 minutes**	**$750**
	Facility Fee		**$1,150**
Procedure Date	**55250 Vasectomy Procedure**	**Z30.2 Male Sterilization**	**$1,000**
	Visit Modifier 25		
	Place of Service 11 (Specialist Office)		
		Total	**$2,900**

SAMPLE

SECTION V: Private Duty Nursing

Enclose a copy of your receipts for these services.

Date of Service (MM-DD-YY)	Name of Nurse	Indicate RN, LPN or CNA	License Number	Hours Worked	Charge
01-05-18	EXAMPLE: Ms. Jane M. Doe	LPN	123456	8	160.00
		-SELECT-			
		-SELECT-			
		-SELECT-			
		-SELECT-			

SECTION VI: Mailing Information

MAIL THIS FORM, ITEMIZED RECEIPTS AND EXPLANATION OF BENEFITS (if applicable) TO:

YOUR HEALTH INSURANCE COMPANY

DID YOU REMEMBER TO:

- Use blue or black ink to complete the form?
- Attach the Explanation of Benefits, if applicable?
- Attach itemized receipts?
- Provide your signature below?
- Keep a copy of this form and your receipts?