MILAN EYE CENTER

CO-MANAGEMENT MANUAL

678.381.2020
milaneyecenter.com

MILAN EYE CENTER

MILAN EYE CENTER was established in 2009 by Dr. Milan Patel in Johns Creek, GA and has been providing state-of-the-art eye care ever since. We currently have seven clinics and six accredited, modern Ambulatory Surgery Centers across North Atlanta.

Our practice is patient-centric, and our goal is to provide the highest level of medical and surgical eye care to our patients. Our doctors are committed to being the best at what they do, and we continue to place a strong emphasis on innovation and focus on the most advanced and effective technology. We provide a myriad of ultra-modern surgical options including bladeless cataract surgery, all laser LASIK, minimally invasive glaucoma surgery, laser guided cornea surgery, biological membrane therapeutics and oculoplastic surgery. Clinically, we offer comprehensive eye care including therapeutic diagnosis and management of glaucoma, diabetic eye disease, ocular infections, inflammatory eye disease, dry eyes, and macular degeneration.

SIGNIFICANTLY, WE DO NOT HAVE AN OPTICAL WITHIN OUR PRACTICE AND DO NOT DISPENSE GLASSES OR CONTACT LENSES.

Our primary focus is to excel in our referral based practice with a strong emphasis on customer service and patient satisfaction. We strive to maintain strong relationships with our referring optometrists and offer educational CE's throughout the year for our referring ODs. Our providers make themselves readily available to all of you and can be directly contacted via cell/email.

We pride ourselves in world class specialty eye care. We ask you to trust that your patients will receive the highest level of surgical expertise and compassionate clinical care.

" After 32 years of practicing Optometry, I have had the opportunity to work with many other professionals in the healthcare industry. After almost 10 years, I can honestly say that Milan Eye Center is one of the most professional organizations I have had the pleasure of being associated with.

These skilled surgeons operate on patients and DO NOT operate optical dispensaries.

The respect for the profession of Optometry is only exceeded by the quality of their surgical services. My patients love using Milan Eye Center and I believe you will also. "

-Don Robbins, O.D.

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CO-MANAGEMENT
POLICY AND PROCEDURE MANUAL

INTRODUCTION

Patients choosing co-management for their pre and postoperative surgical care experience the benefits and convenience of continuity of care by their Primary Eye Care Provider (PECP). This manual outlines the process that Milan Eye Center follows for the co-management treatment of cataract and refractive surgery patients. Together with our co-managing doctors, we will provide the highest quality of care for our shared patients.

Milan Eye Center is pleased to offer primary eye care providers an opportunity to participate in the pre and postoperative portions of the surgical process. These guidelines comply with applicable state and federal statutes and regulations regarding co-management of patient care and referral arrangements.

1. The selection of an operating surgeon for patient referral will be based on providing the best potential outcome and convenience for the patient. Financial relationships between providers will not be a factor.

2. The patient's right to choose the method of postoperative care will be recognized and will be consistent with the best medical interest of the patient.

3. Co-managing doctors will be ODs or MDs licensed to practice in Georgia.

4. The transfer of postoperative care will always be clinically appropriate and depend on the particular facts and circumstances of the surgical event.

5. Following surgery, transfer of care from the operating surgeon to the co-managing provider will occur when clinically appropriate at a mutually agreed upon time or circumstance, and such time will be clearly documented via correspondence and included in the patient's medical record. This information will be included in the referral letter from the ophthalmic surgeon to the co-managing provider at the time of transfer of care.

6. The operating surgeon and the co-managing provider will communicate during the postoperative period to assure the best possible outcome for the patient. In facilitating this goal, PECPs are asked to send clinical documentation of postoperative visits to Milan Eye Center.

7. Compensation for care will be commensurate with the services provided. Cases involving care for Medicare beneficiaries will reflect the proper use of modifiers and other Medicare billing instructions.

Step-by-step instructions and co-management forms are provided in the following sections of this manual.

STEP-BY-STEP PROCESS
for SURGICAL CO-MANAGEMENT

The patient is seen by his/her Primary Eye Care Provider (PECP) and charged the usual and customary fee for a complete examination. The doctor identifies the patient's need for cataract surgery or other eye procedure or the patient's desire for refractive surgery and completes the Pre-Op Co-Management Exam and Consultation Request Form and faxes to 678.381.2015. Note: **The PECP can use internal forms in lieu of the forms in this manual or EMR notes documenting a consultation request.**

1. The referring PECP educates the patient regarding the process of cataract or refractive surgery.

2. The referring PECP discusses the typical co-management treatment plan and explains what care will be provided by the ophthalmic surgeon and the optometric physician (a fax cover sheet is provided in this manual).

3. The Patient Coordinator (PC) at Milan Eye Center contacts the patient and schedules an appointment for a consultation. The PC will attempt to notify the referring PECP if the patient declined to book the appointment. The PECP office may also book an appointment for the patient at the time of referral if so desired. Lastly, the patient may choose to call and schedule an appointment at their convenience.

4. The patient is examined by the surgeon and a determination of medical necessity for cataract surgery is made. In the case of refractive surgery, the patient's candidacy is assessed. The patient is educated on which procedure best suits their needs i.e. LASIK / PRK / INTACS / Corneal Crosslinking. For cataract surgery, recommendation for applicable advanced technology IOLs is made.

5. Any necessary preoperative testing is performed during the patient's initial visit with the surgeon. The patient will then meet with a surgical coordinator to schedule surgery. At this time, the patient will complete and sign all patient consent forms and necessary documents. The patient will also sign applicable Co-Management Consent forms at this time.

6. The surgeon will send a letter to the referring PECP regarding the findings of the consultation, pre-op testing and decision for the surgery, if applicable.

7. When deemed medically appropriate, typically after the first postoperative visit, the surgeon forwards the postoperative medical record, which includes surgery information and findings from the previous postoperative visits and faxes the form to the co-managing PECP.

8. Following each postoperative visit (1d, 1wk, 1mo as applicable), the co-managing PECP will fax a postoperative co-management exam form to Milan Eye Center (or a copy of the patient's chart notes). In the case of cataract surgery, usually at the one month visit, the PECP will perform the final follow-up, refraction and provide glasses, if necessary. In the case of multifocal, EDOF (Extended Depth Of Focus), and toric IOLs, additional postoperative visits at 3 and 6 months are scheduled, and the patient is dilated as appropriate.

9. Upon completion of postoperative care, the PECP will submit the appropriate claim to third party payers. The PECP should be a participating provider with Medicare and will bill and be paid directly by Medicare. Information regarding billing the PECP's portion of the co-managed care is provided in this manual.

PRE-OP CO-MANAGEMENT EXAM and CONSULTATION REQUEST FORM

Patient Name: _____ DOB: _____ Date: _____

Patient phone: Home : _____ Work: _____ Cell: _____

I am sending this patient to you for assistance with his/her care. Please evaluate this patient's problem(s) or condition(s). Reason for Consultation: _____ and consider treatment as appropriate. I look forward to receiving your opinion and advice regarding care of this patient and will resume general care following your consultation.

Co-managing PECP: _____ Phone: _____ Fax: _____ NPI# _____

Is Co-managing PECP contracted with patient's **medical** insurance? Yes No

Patient's Medical Insurance Company: _____

Office Contact: _____ E-Mail Address: _____

CLINICAL INFORMATION

Ocular History: _____

Examination: VAsc OD: _____ VAcc OD: _____ Pupils (dim light): _____

OS: _____ OS: _____ Fields: _____ EOM: _____

Near Vision: OD: _____ OS: _____

Keratometry: OD: _____ OS: _____

Manifest Refraction OD: _____ 20/_____

OS: _____ 20/_____

IOP: (Goldman/Non Con/Other) OD: _____ OS: _____

Slit Lamp Exam:

OD: _____

OS: _____

Dilated Fundus Exam:

OD: _____

OS: _____

Type of CLs: _____ Time out of CLs: _____

☐ **Activities of daily living are impaired because of decreased vision.**

Additional Comments: _____

_____

MILAN EYE CENTER

FAX COMPLETED FORM TO: 678.381.2015

OPTIONAL FORM You may use your own internal forms or eye record with clear documentation of a consultation request.

LASIK
CO-MANAGEMENT FORM

PLEASE **SIGN** AND FAX BACK TO MILAN EYE CENTER AT 678.381.2015

RETAIN IN PATIENT FILE.

Patient Name: _____ DOB: _____ Date: _____

Manifest Refraction OD: _____ Date of Manifest Refraction: _____

OS: _____

Cyclopegic Refraction OD: _____ Date of Cyclopegic Refraction: _____

OS: _____

IOP (Goldman / Non Con / Other) OD: _____ OS: _____

Findings of Dilated Fundus Exam OD: _____ Date of DFE: _____

OS: _____

History of contact lens wear: Yes No

Soft Lenses / RGP Lenses?

For how long? _____

History of monovision: Yes No

If yes, then since when? _____

Patient needs to be reminded to be out of soft contact lens for 2 weeks prior to LASIK evaluation plus 2 days prior to the procedure.

I, as the co-managing doctor, understand that the patient will require both preoperative and postoperative counseling and understanding of his/her expected visual outcome and this would include co-managing subsequent refractive enhancement with possible contact lens trial.

SIGNATURE: _____ **DATE:** _____ / _____ / _____

Impression / Comments: _____

_____

_____

_____

MILAN EYE CENTER

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OPTIONAL FORM You may use your own internal forms or eye record with clear documentation of a consultation request.

POSTOPERATIVE EXAMINATION and MEDICATION SCHEDULE CATARACT SURGERY

Outlined below is a brief description of the typical cataract postoperative schedule. It is important that patient's follow-up care be documented in written form, not only for medical, but for medico-legal considerations. Fax a completed Post-Op Exam form or Exam Note to Milan Eye Center following each patient visit. Should you have any questions, do not hesitate to call us at 678.381.2020. Contact the surgeon immediately if any complication arises.

VISIT	EXAMINATION DESCRIPTION (PER EYE)
Day 0	Patient undergoes surgery.
Day 1	First postoperative examination by surgeon or PECP
Days 2 - 6	Patient remains under the care of the surgeon or PECP. The patient may have no scheduled visits but may see the surgeon or PECP as needed.
Days 7 - 30	PECP takes over care of patient. Complete the "Post-Op Exam Form" or Exam Note and fax to surgeon following each visit. Refraction and evaluation of second eye and referral for cataract evaluation and surgery if indicated.
Day 30	Examination by co-managing PECP. PECP may dispense refraction at their discretion.
3 month, 6 month, 1 year	Examination by co-managing PECP (3 month, 6 month and 1 year only for multifocal patients or EDOF IOLs as needed). For multifocal and toric patients, PECP may refer back after the 3 month visit to the surgeon if enhancement is needed. Dilation to ascertain and document axis of toric is encouraged prior to referral back to surgeon.

On each exam, the following observations need to be recorded on a post-op form and faxed to our center:
FAX Line: 678.381.2015▪
Phone Line: 678.381.2020

- Vision without correction and through a pinhole
- Slit lamp exam
- Intraocular pressure
- Refraction status w/visual acuity and near vision (if applicable)

TIME	MEDICATIONS	COMMENTS Patient will be provided medication regimen handout or will be using the Easy Drops app.
Day 1 – 7	Antibiotic, steroid, and NSAID as prescribed by surgeon.	Steroid may be tapered more slowly or increased based on signs of inflammation.
Day 8 – 28	Steroid and NSAID as prescribed by surgeon.	Steroid may be tapered more slowly or increased based on signs of inflammation.
Day 1 – 30	Preservative free artificial tears: Non-preserved lubricating drops can be used as frequently as desired.	Use lubrication longer if needed.

POSTOPERATIVE EXAMINATION and MEDICATION SCHEDULE
REFRACTIVE SURGERY

Outlined below is a brief description of the typical LASIK and PRK postoperative schedule. It is important that patient's follow-up care be documented in written form, not only for medical, but for medico-legal considerations. Fax a completed Post-Op Exam form to Milan Eye Center following each patient visit. Should you have any questions, do not hesitate to call us at 678.381.2020. Contact the surgeon immediately if any complication arises.

OUTLINED BELOW IS THE POSTOPERATIVE EXAMINATION SCHEDULE FOR LASIK PATIENTS.

VISIT	EXAMINATION DESCRIPTION (PER EYE)
Day 0	Patient undergoes surgery.
Day 1	Examination by PECP or Surgeon.
Week 1	Examination by PECP. **Avoid IOP Check over flap.**
1 Month	Examination by PECP: Manifest Refraction.
3 Month	Examination by PECP: Manifest Refraction.
6 Month	Examination by PECP: Manifest Refraction. Evaluation need for any enhancement.

OUTLINED BELOW IS THE POSTOPERATIVE EXAMINATION SCHEDULE FOR PRK PATIENTS.

VISIT	EXAMINATION DESCRIPTION (PER EYE)
Day 0	Patient undergoes surgery.
Day 1	Examination by PECP or Surgeon.
Day 4-7	Examination by PECP.
1 Month	Examination by PECP: IOP Check and Manifest Refraction. If IOP elevates, treat and return at post-op month 2 or earlier.
3 Month	Examination by PECP. IOP Check and Manifest Refraction.
6 Month	Examination by PECP: IOP Check and Manifest Refraction. Evaluate need for enhancement, if any. Advise patient to return for one year complete exam.

OUTLINED BELOW IS THE POSTOPERATIVE MEDICATION SCHEDULE FOR LASIK PATIENTS.

TIME	MEDICATIONS	COMMENTS
Day 1 – 7	Antibiotic and steroid as prescribed by surgeon.	Patient will be provided medication regimen handout or will be using Easy Drops app.
Week 2	Extend steroid therapy and / or antibiotic therapy if necessary and per clinical need.	Patient will be provided medication regimen handout or will be using Easy Drops app.
First 6 months	Restasis if prescribed preoperatively.	2 times per day for 6 months and beyond as necessary.
First 9 months	**Preservative free** artificial tears	6-8 times per day encouraged

OUTLINED BELOW IS THE POSTOPERATIVE MEDICATION SCHEDULE FOR PRK PATIENTS.

TIME	MEDICATIONS	COMMENTS
Day 1 – 7	Antibiotic, steroid, Neurontin, and narcotic as prescribed. (Narcotic not routinely prescribed)	Patient will be provided medication regimen handout or will be using Easy Drops app.
Week 2 through Week 8	Steroid taper as prescribed.	Patient will be provided medication regimen handout or will be using Easy Drops app.
First 6 months	Restasis if prescribed preoperatively	2 times per day for 6 months
First 9 months	**Preservative free** artificial tears	6-8 times per day encouraged

At each postoperative exam, the following observations need to be recorded on a post-op form or medical record and faxed:
Milan Eye Center at: 678.381.2015▪

- Visual acuity
- Refraction
- IOP
- Patient's opinion of night vision (same, better, worse)
- Slit lamp exam

CO-MANAGEMENT
CONSENT FORM

CAN BE COMPLETED BY CO-MANAGING PECP OR MILAN EYE CENTER

PLEASE KEEP IN PATIENT FILE.

Patient Name: _____

Dr. _____ will be performing _____ on me.
(Name of surgery)

It is my desire to have my primary optometrist/ophthalmologist, Dr. _____,
(Name of PECP)
perform my preoperative and/or postoperative care.

I understand that a record of findings will be sent to my surgeon following each visit with my primary eye care provider and that my surgeon will be informed if I experience any complications related to my eye surgery.

I understand that I may also contact my surgeon at any time after the surgery.

I understand that there are **no additional fees** associated with co-management and that Milan Eye Center will collect outstanding fees, if any, above those individually billed to insurance and forward the appropriate co-management fee to

Dr. _____ for postoperative care.
(Name of PECP)

DATE: _____ / _____ / _____

SIGNATURE: _____

WITNESS: _____

MILAN EYE CENTER

FAX COMPLETED FORM TO: 678.381.2015

OPTIONAL FORM You may use your own internal forms or eye record with clear documentation of a consultation request.

CO-MANAGEMENT

TRANSFER OF CARE FORM

PLEASE **SIGN** AND FAX BACK TO MILAN EYE CENTER

RETAIN IN PATIENT FILE.

Patient Name: _____

D.O.B. _____ / _____ / _____ Home Phone: _____

Medicare #: _____ Other Insurance: _____

Date of Surgery: _____ OD OS

Procedure/Lens: _____

Diagnosis Code: _____ CPT code: _____

Facility: AMBULATORY SURGICAL CENTERS OF MILAN EYE CENTER

Co-Managing Optometrist: _____

Date Post-Op Care Began: _____ / _____ / _____ Date Post-Op Care Ended: _____ / _____ / _____

Post-Op Uncorrected VA: OD 20/ _____ OS 20/ _____

Post-Op Exam Findings: _____

_____

_____

Medications: _____

_____

Post-Op visits to schedule for this patient:

☐ _____ ☐ 30 Day ☐ 90 Day ☐ 6 Mo. ☐ 1 Yr.

Surgeon Signature: _____ Date: _____ / _____ / _____

I accept the Transfer of Care for the above mentioned patient:

PECP SIGNATURE: _____ **DATE:** _____ / _____ / _____

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POSTOPERATIVE ASSESSMENT FORM

FOLLOW-UP DATE: _____ / _____ / _____

Patient Name: _____ OD OS OU

Surgeon: _____

Surgery Date: _____ / _____ / _____ Co-Managing Doctor: _____

Procedure: (circle one) Monofocal IOL Toric IOL EDOF IOL Multifocal IOL PRK LASIK

OD 1 Day 1 Week 1 Month 6 Months (circle one)

OS 1 Day 1 Week 1 Month 6 Months (circle one)

Other OD _____ OS _____

(Include slit lamp and dilated fundus exam as needed.)

Subjective Findings: _____

_____

_____

Assessment: **OD**

VA sc 20/_____

Refraction: _____20/_____

Keratometry _____ /_____ @ _____ (auto/manual)

Cornea _____ Clear Other _____

_____

_____

Assessment: **OS**

VA sc 20/_____

Refraction: _____20/_____

Keratometry _____ /_____ @ _____ (auto/manual)

Cornea _____ Clear Other _____

_____

_____

Intraocular Pressure: _____ mm/hg

Intraocular Pressure: _____ mm/hg

Medications: _____

Impression/Comments: _____

_____

Next planned visit: _____ / _____ / _____ Doctor Signature: _____

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FAX COMPLETED FORM TO: 678.381.2015

OPTIONAL FORM You may use your own internal forms or eye record with clear documentation of a consultation request.

MILAN EYE CENTER

FAX
COVER SHEET

OUTPATIENT SURGICAL PROCEDURES

FAX TO MILAN EYE CENTER: 678.381.2015

FROM CO-MANAGING PECP: _____

FAX NUMBER: _____

DATE: _____

PATIENT: _____

PECP #: _____

Enclosed:

- ☐ Consult Request Form
- ☐ Signed Transfer of Care Form
- ☐ Post-op Form
- ☐ Other (specify):

Comments: _____

_____

_____

_____

The PHI (Protected Health Information) contained in the FAX is HIGHLY CONFIDENTIAL. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.

PATIENT INFORMATION SHEET

CO-MANAGEMENT
TREATMENT PLAN

This information is designed for patients who have been diagnosed as having cataracts and who intend to have cataract surgery as well as patients who have opted to have refractive (LASIK or PRK) surgery. Any surgical procedure contains some element of risk in the post-operative period. For your health and safety, it is imperative that you receive proper follow-up care after your cataract surgery. This fact sheet will explain what follow-up care is and who is qualified to perform it for you.

WHAT IS FOLLOW-UP CARE?

After your surgery, you will have several appointments with an eye care professional. You should understand that complications may not necessarily occur during surgery but may occur after the surgery has been performed. For this reason, it is imperative that you have appropriate care by a qualified eye care professional following your surgery. Your doctor will ensure that any post-surgical complications are detected and treated. In addition, he or she will perform tests to measure your visual acuity and, if necessary, fit you for eyeglasses. This series of visits is called your "follow-up care."

WHO IS QUALIFIED to PROVIDE FOLLOW-UP CARE?

It is critical that your follow-up care be performed by a qualified eye care professional familiar with your case. Several different practitioners are qualified to provide this service. You should understand the roles that each may play in your recovery.

> Your Surgeon: Your surgeon is a licensed ophthalmologist, a medical doctor who specializes in diseases of the eye and who will perform your surgery. Your surgeon may see you one day after surgery to ensure that your recovery is progressing normally. Your surgeon will also determine when you can be released from his or her care to return to your optometrist for further follow-up visits.
>
> Your Optometrist: While you may request to receive your follow-up care from your surgeon, Doctors of Optometry are eye care professionals trained, licensed, and fully qualified to provide follow-up care once you are released by your surgeon. Most patients find it very convenient to return to their optometrist for postoperative care and services on day one. Your optometrist is also the vision specialist who will examine and fit you for your glasses, if necessary, after cataract surgery. Your optometrist will be in communication with your surgeon following each postoperative visit. If problems develop during the postsurgery follow-up period, your optometrist and your surgeon will communicate regarding your care until these have resolved. **It is recommended that you follow up with your Optometrist after surgery.**
>
> Another Ophthalmologist: If you travel away from home to have surgery and wish to return home soon after surgery or if you have any other personal reason for not receiving your follow-up care from your surgeon or optometrist, you may decide to see another ophthalmologist for your follow-up care. An ophthalmologist other than your surgeon can perform all of your follow-up care after your initial visit with your surgeon one day after surgery. You must, however, make arrangements with the ophthalmologist and notify your surgeon before having surgery. Your surgeon will only discharge you from his or her care if he or she has confidence in the professional who will supervise your recovery.

Summary

We hope this summary has helped to explain some facts about the cataract surgical process. Your optometrist and surgeon will explain the improvements in your vision that you may enjoy after cataract surgery. If you have any questions or concerns, now is the time to address them. You may contact your optometrist or your surgeon at any time, before or after surgery, to answer your questions or address concerns.

BILLING INSTRUCTIONS and FEES
CATARACT CO-MANAGEMENT BILLING for MEDICARE

As per guidelines published by Medicare in 1992, specific components of major surgery were defined as the "global surgery package." The components they identified included preoperative care, intraoperative services, postoperative care (90 days), and in-office care for any postoperative complications. In addition, the value of postoperative care for surgical procedures was standardized and postoperative care for ophthalmic surgery was valued at 20% of the global surgery package. Medicare also published instructions to Medicare carriers on split billing of postoperative care, also known as postoperative co-management, within eye care. These instructions incorporated the following points:

1. Co-management requires a written transfer agreement between the surgeon and the receiving doctor(s).

2. Specific modifiers must be used on claims (54 - surgical care only; 55 - postoperative management only).

3. The receiving doctor cannot bill for any part of the service included in the global period until he/she has provided at least one service.

4. The comments provided herein relate to billing for cataract co-management for Medicare patients. Commercial carrier policies will vary. Should you have questions about a specific carrier's policy, we recommend you contact them directly. Also, if you have questions related to Medicare billing procedures, you can visit their website, www.cms.gov, or contact our office for assistance.

5. Medicare uses chronology and number of days to calculate payment for care rendered by each doctor during the postoperative period (90 days). The fees submitted by the surgeon and PECP will be different, depending on the number of days of postoperative care each one (has) provided.

MODIFIERS FOR CLAIMS SUBMISSION

6. After the PECP has seen the patient for the patient's first postoperative visit, he/she will submit a health insurance claim for the post-operative care provided, using the appropriate CPT code, i.e, 66984, modifier 55, and modifier RT or LT. Again, in order for the claim to be accurate, the PECP must know the date he/she assumed responsibility for postoperative care (the transfer date).

7. Many patients will have cataract surgery performed on the second eye shortly after their first surgery, in which case postoperative care may overlap temporarily. When these patients are co-managed, claims for each surgery are handled separately. For the second surgery (different eye), the health insurance claim form will include modifiers 55, 79, and RT or LT for the PECP.

WRITTEN TRANSFER AGREEMENT (Cataract and Refractive Surgery)

The transfer agreement between the surgeon and the co-managing doctor contains the surgeons discharge instructions and the effective transfer date. According to current Medicare policy, the transfer date is "determined by the date of the physicians transfer order." The responsibility for postoperative care may be transferred on or before the patient's appointment for the subsequent follow-up visit with the receiving doctor, who may submit a claim for services once he has seen the patient. The split of postoperative care cannot be done or pre-arranged in advance of the surgery. Instead, a unique transfer agreement should be constructed for each patient. The essential elements of the Transfer of Care Form from the surgeon to the PECP should include the following:

1. Patient Name
2. Operative Eye
3. Nature of Operation
4. Date of Surgery
5. Clinical Findings
6. Discharge Instructions
7. Transfer Date

The PECP should assume care of the patient on the following day. This form determines the "transfer date," as well as corresponding reimbursement for claims submitted. Because the surgeon cannot be certain the patient will actually keep the appointment with the PECP, communication from the PECP is necessary and is evidence that the PECP actually saw the patient and is in compliance with CMS requirement that the PECP "...has provided at least one service." Both doctors should retain copies of this documentation as part of the patient's permanent records. They may also serve as a useful attachment on claims as necessary.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. H25.11 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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	05	03	16	05	03	16	11		66984	55 RT	A	1000 00	1		NPI	Individual Co-Man NPI
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

Co-Man Practice Tax ID X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

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.)

Co-Man Signature / Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Practice Location

a. Group NPI b. Practice Tax ID

33. BILLING PROVIDER INFO & PH # ( )

Billing Location

a. Group NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY | STATE

8. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. H25.12 B. C. D.

E. F. G. H.

I. J. K. L.

22. 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	05	17	16	05	17	16	11		66984	55 79 LT	A	1000 00	1		NPI	Individual Co-Man NPI
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

Co-Man Practice Tax ID X

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

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.)

Co-Man Signature / Date

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Practice Location

a. Group NPI b. Practice Tax ID

33. BILLING PROVIDER INFO & PH # ( )

Billing Location

a. Group NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

FEE STRUCTURE for CO-MANAGEMENT

PROCEDURE	ADVANCED TECHNOLOGY FEE
Multifocal IOL	20% of professional reimbursement per eye
EDOF IOL	20% of professional reimbursement per eye
Toric IOL	20% of professional reimbursement per eye
LASIK	20% of fee paid per eye
PRK	20% of fee paid per eye

*Patient only seen once by the referring physician may not result in a fee for advanced technology IOL's.