**INSTRUCTIONS FOR BILLING MED-PAY**
**INSTRUCTIONS FOR RE-SUBMITTING REDUCED MED-PAY CLAIMS**

Dear Doctors:

Here is a sample of how my chiropractic office bills med pay insurance. The sample letter to AAA is an example of what was sent the FIRST time this claim was submitted. The claim was paid in full.

1. Note that my office wrote "SUPPLEMENT" and circled the diagnosis section on one of the HCFA forms. Since one of the HBTI Diagnosis forms was submitted along with the billing, writing "SUPPLEMENT" on the HCFA form directs them to look at *all* the diagnoses on that form.
2. Note that we submitted the HBTI Symptoms form along with the Diagnosis Form when we sent the billing. We also submit an HBTI Treatment Plan form when the billing includes treatment. (This claim was for the first date of service only.)
3. An IRREVOCABLE Assignment of Benefits was sent to the med pay company. A sample of this can be downloaded from the HBTI website and edited for your office's use. Using this form is the only way you can stop unscrupulous attorneys from stealing the med pay.

Submitting claims in this manner will get you paid in full the first time and you generally will not have to re-submit claims. It is very, very, very important that you write in your letter that the patient will be "balance billed" for any amount the company does not pay. If they cut your bill, they could be sued by their own insured for bad faith (for a LOT of money.) That is why those words "balance billed" are magical.

In summary:

1. Use the HBTI forms: Symptoms, Diagnosis, and Treatment Plan and submit them with your billing.
2. Put a cover letter with your bills similar to the sample here.
3. Circle the Diagnosis section on the HCFA form and write "SUPPLEMENT" on it.
4. Use the magic words, "balance billed" in your cover letter

**RE-SUBMITTING DENIED CLAIMS**

Follow the same steps outlined above. Submit all your forms, put a cover letter, circle the diagnosis section and write "SUPPLEMENT" across one of your HCFA forms, and use the magic words. In a re-submission, make the last sentence bold type (the one that uses the magic words, "balance billed."

Eggleston Chiropractic Offices
21521 Brookhurst St.
Huntington Beach, CA 92646
Phone (714) 962-7103
Facsimile (714) 965-1368

# FACSIMILE

*Sent via the fax (213) 741-3192* *Total Pages* 16

May 9, 2008

Attn: Wendy Kight
AAA

Re: [redacted]
Claim # [redacted]
Insured: [redacted]

Here is the first billing for [redacted]. If you have any questions please do not hesitate to call our office. I have included our Assignment of Benefits authorization as well as a Symptoms form, Diagnosis sheet, and copies of Epworth, Rivermead and Folstein interview and exam forms with Analysis to help provide you with all the information you will need to process her claim.

Please feel free to contact this office and speak with Dr. Eggleston personally if you have any questions regarding treatment. Please be advised that any balance that is not covered by AAA will be balance billed to Ms. [redacted]

Very sincerely,
Donna
Eggleston Chiropractic Office

FAXED 5/9/08

NOTE: Be sure to state the patient will be "balance billed" any amount the insurance company does not pay.

# IRREVOCABLE ASSIGNMENT OF BENEFITS

Patient Name: [redacted]

Claim # [redacted]308 DOI: 4/23/2008

SSN/ID # [redacted]

Insured's Name [redacted] Relation to Insured [redacted]

I hereby instruct and direct the AAA Insurance Company to pay the benefits of my policy by check made out to and mailed directly to

**Dr. Steven C Eggleston, Esq.**
**21521 Brookhurst St.**
**Huntington Beach, CA 92646**

**OR**

If my policy prohibits direct payment to a doctor, then I hereby also instruct and direct you, my insurance company, to make the check out to me and mail it as follows:

**C/O Dr. Steven C Eggleston, Esq.**
**21521 Brookhurst St.**
**Huntington Beach, CA 92646**

For the professional or chiropractic/medical benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY AND IS IRREVOCABLE, EVEN BY MY ATTORNEY. DO NOT PAY THE BENEFITS OF THIS POLICY TO MY ATTORNEY AND DO NOT MAIL ANY BENEFIT CHECKS TO MY ATTORNEY. Said payment will not exceed my indebtedness to Dr. Steven C Eggleston, Esq. and I have agreed to pay, in a current manner, any balance of said professional services fees over and above this insurance payment. If my policy is an indemnity policy, I hereby direct you, my insurance company, to indemnify me against the harm that would occur should Dr. Steven C Eggleston, Esq. have to balance bill me for professional fees that I contracted for and that you, my insurance company, fail to pay or fail to pay in full.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize Dr. Steven C Eggleston, Esq. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I further authorize Dr. Steven C Eggleston, Esq. to file a complaint on my behalf with the California Insurance Commissioner or the California Department of Managed Health Care.

Date: 4/30/08

Signature of Policyholder: _____

Signature of Claimant, if other than Policyholder: [redacted]

aob.doc

# Symptoms

Patient [redacted] Date 4/29/08 Date of Injury 4/23/08

☐ Initial ☐ Update

**Please check all symptoms you currently have *that you did not have before* the accident.**

- ■ Sleepiness
- ■ Nausea
- ■ Vomiting
- ☐ Seizure
- ■ Difficulty Concentrating
- ☐ Suddenly Start Dreaming
- ☐ Mindless Staring
- ■ Mood Swings
- ■ Agitation
- ■ Sadness
- ■ Blurry Vision
- ☐ Double Vision
- ■ Disoriented
- ■ Confused
- ☐ Difficulty Speaking
- ■ Headache
- ■ Attention Problems
- ■ Appetite Change
- ☐ Pupils Different Sizes
- ■ Dizziness
- ■ Balance Problems
- ☐ Difficulty Walking
- ■ Groggy
- ■ Very Tired
- ■ Dozing During The Day
- ■ Personality Change
- ☐ Can't Remember Numbers
- ☐ Reading Problems
- ☐ Writing Problems
- ☐ Difficulty with Adding/Subtracting
- ☐ Poor Attention
- ☐ Difficulty Learning New Things
- ☐ Difficulty Understanding
- ■ Difficulty Remembering
- ■ Re-reading Things to Understand It
- ■ Anger
- ☐ Difficulty Making Decisions
- ☐ Slurred Speech
- ■ Depression
- ■ Change in Sexual Functioning
- ■ Hopelessness
- ■ Reduced Confidence
- ■ Helplessness
- ■ Apathy (Don't Care)
- ■ Irritable
- ■ Flashbacks to Accident
- ■ Impatience
- ■ Frustration
- ☐ Wanting to be Alone
- ■ Fatigue
- ■ Hearing Problems Ringing in ears
- ☐ Change in Sense of Taste
- ☐ Change in Sense of Smell
- ■ Sleeping Problems
- ☐ Difficulty with Hand Coordination
- ☐ Difficulty Planning or Organizing
- ■ I am more easily Distracted
- ☐ Social Withdrawal
- ☐ Feeling Isolated
- ☐ "Clunk" Sound with Neck Movements
- ■ Jaw Pain Left sided
- ■ Clicking in Jaw
- ☐ Pain when Chewing
- ☐ Numbness in Arms or Hands
- ☐ Numbness in Legs or Feet
- ■ Tingling in Arms or Hands Left side
- ■ Tingling in (Legs) or Feet Left side
- ■ Weakness in Arms or Hands
- ☐ Weakness in Legs or Feet
- ■ Neck Pain Left & center
- ■ Upper Back Pain
- ■ Low Back Pain

| | | |
|---|---|---|
| ■ Shoulder Pain L- | ■ Left | ☐ Right |
| ■ Upper Arm Pain | ☐ Left | ☐ Right |
| ☐ Elbow Pain | ☐ Left | ☐ Right |
| ☐ Forearm Pain | ☐ Left | ☐ Right |
| ☐ Wrist Pain | ☐ Left | ☐ Right |
| ☐ Hand Pain | ☐ Left | ☐ Right |
| ■ Hip Pain | ■ Left | ☐ Right |
| ■ Upper Leg Pain | ■ Left | ☐ Right |
| ☐ Knee Pain | ☐ Left | ☐ Right |
| ☐ Lower Leg Pain | ☐ Left | ☐ Right |
| ☐ Ankle Pain | ☐ Left | ☐ Right |
| ☐ Foot Pain | ☐ Left | ☐ Right |

- ■ Face Pain Left sided
- ■ Chest Pain
- ☐ Stomach Pain
- ■ Bruise to Left Forearm & Left Upper Leg
- ☐ Scrape/Cut to
- ■ Other Symptom hurts to swallow
- ■ Other Symptom heart burn

**Diagnosis** for [redacted] Date of Injury: 4/23/08

Diagnosis Status: ■ Initial ☐ Update Date of Diagnosis: 4/29/08

## Cervical Spine Injuries

- ■ 847.0 Cervical Sp/St
- ■ 739.0 Occipitocervical Sublux.
- ■ 739.1 Cervicothoracic Sublux.
- ■ 728.4 Cerv. Ligt. Laxity
- ■ 728.5 Cerv. Hypermobility
- ☐ 720.1 Cerv. Enthesopathy
- ■ 723.1 Cervicalgia
- ■ 728.85 Cerv. Myospasm
- ■ 729.1 Cervical Myalgia
- ☐ 737.29 Loss of Cerv. Lordosis
- ☐ 737.19 Traumatic Cerv. Kyphosis
- ☐ 738.2 Acquired Cerv. Deformity
- ☐ 722.0 Cerv. Disk Herniation/Neuritis
- ■ 953.0 Cerv. Nerve Injury
- ☐ 723.3 Cervicobrachial Nerve Injury
- ■ 782.0 Cerv. Sensation Disturbance
- ☐ 728.2 Upper Extremity Atrophy
- ■ 728.9 Upper Extremity Weakness
- ■ 722.4 Cervical DJD/DDD
- ☐ 722.81 Post Cervical Laminectomy

## Thoracic Spine Injuries

- ■ 847.1 Thoracic Sp/St
- ■ 739.2 Thoracolumbar Sublux.
- ■ 728.4 Thor. Ligt. Laxity
- ☐ 728.5 Thor. Hypermobility
- ☐ 720.1 Thor. Enthesopathy
- ■ 724.1 Thoracalgia
- ■ 728.85 Thoracic Myospasm
- ■ 729.1 Thoracic Myalgia
- ☐ 848.3 Ribs Sprain/Strain
- ☐ 739.8 Rib Cage Subluxation
- ☐ 848.41 Sternoclavicular Sp/St
- ☐ 786.50 Chest Pain
- ☐ 722.11 Thor. Disc Herniation
- ☐ 853.1 Thor. Nerve Injury
- ☐ 724.4 Thoracic Neuritis
- ☐ 953.4 Brachial Plex. Nerve Inj.
- ☐ 353.0 Brachial Plexus Lesion
- ☐ 722.51 Thoracic DJD/DDD

## Lumbar Spine Injuries

- ■ 847.2 Lumbar Sp/St
- ■ 739.3 Lumbosacral Sublux
- ☐ 728.4 Lumb.Ligt.Laxity
- ☐ 728.5 Lumb.Hypermobility
- ☐ 720.1 Lumb. Enthesopathy
- ■ 724.2 Lumbago
- ■ 728.85 Lumb. Myospasm
- ■ 729.1 Lumbar Myalgia
- ☐ 722.10 Lumbar Disk Herniation
- ☐ 953.2 Lumbar Nerve Injury
- ☐ 724.4 Lumbar Neuritis
- ☐ 782.0 Sensation Disturbance
- ☐ 728.2 Leg Atrophy
- ☐ 728.9 Leg Muscle Weakness
- ☐ 729.5 Leg Limb Pain
- ☐ 729.81 Leg Swelling
- ☐ 722.52 Lumb DJD/DDD
- ☐ 722.83 Post Laminectomy
- ☐ 756.12 Spondylolisthesis
- ■ 719.7 Difficulty Walking

## Upper Extremity Injuries

- ■ 739.7 Upper Extremity Subluxation
- ☐ 728.85 Upper Extremity Myospasm
- ☐ 719.46 Upper Extremity Joint Pain
- ☐ 729.81 Upper Extremity Swelling
- ☐ 729.5 Upper Extremity Tissue Pain
- ■ 840.9 Shoulder Sprain/Strain
- ☐ 719.46 Shoulder Pain
- ☐ 726.10 Shoulder Enthesopathy
- ☐ 841.9 Elbow Sprain/Strain
- ☐ 739.7 Elbow Subluxation
- ☐ 726.3 Elbow Enthesopathy
- ☐ 842.00 Wrist Sprain/Strain
- ☐ 739.7 Wrist Subluxation
- ☐ 726.4 Wrist Enthesopathy
- ☐ 842.10 Hand Sprain/Strain
- ☐ 739.7 Hand Subluxation

## Lower Extremity Injuries

- ■ 739.6 Lower Extremity Subluxation
- ☐ 728.85 Lower Extremity Myospasm
- ☐ 719.46 Lower Extremity Joint Pain
- ☐ 729.81 Lower Extremity Swelling
- ☐ 729.5 Lower Extremity Tissue Pain
- ■ 843.9 Hip/Thigh Sprain/Strain
- ☐ 726.5 Hip Region Enthesopathy
- ☐ 844.9 Knee Sprain/Strain
- ☐ 726.6 Knee Enthesopathy
- ☐ 845.00 Ankle Sprain/Strain
- ☐ 726.7 Ankle/Foot Enthesopathy
- ☐ 845.10 Foot Sprain/Strain
- ☐ 719.7 Difficulty Walking

## Pelvis/Hip/Sacrum

- ■ 846.9 Sacroiliac Sp/St
- ■ 739.4 Sacroiliac Sublux.
- ☐ 847.3 Sacrum Sp/St
- ☐ 724.6 Sacrum Instability
- ☐ 847.4 Coccyx Sp/St
- ■ 739.5 Hip/Pelvis Sublux.
- ☐ 724.3 Sciatic Neuritis
- ☐ 956.0 Sciatic NI
- ☐ 953.3 Sacral NI

## Abrasions

- ☐ 910.0 Face, Neck, Head
- ☐ 911.0 Abdomen, Torso
- ☐ 912.0 Shoulder & Arm
- ☐ 913.0 Elbow, Arm, Wrist
- ☐ 914.0 Hand & Fingers
- ☐ 916.0 Hip/Thigh/Leg/Ankle
- ☐ 917.0 Foot & Toes

## Contusions

- ■ 920.0 Face, Neck, Head
- ■ 922 Abdomen, Torso
- ■ 923.0 Shoulder & Arm
- ☐ 923.1 Elbow, Arm, Wrist
- ☐ 923.2 Hand & Fingers
- ■ 924.0 Hip/Thigh/Leg/Ankle
- ☐ 924.2 Foot & Toes

## Brain Injuries

- ■ 850.0 Concussion/No LOC
- ☐ 850.1 Concussion/Brief LOC
- ☐ 850.2 Concussion Mod. LOC
- ■ 854.00 Traumatic Brain Injury
- ☐ 907.0 Late FX of Brain Injury
- ■ 784.0 Headache
- ■ 780.8 Sleep Disturbance
- ■ 780.89 Somnolescence
- ■ 780.7 Fatigue/Lethargy/Tired
- ■ 787.0 Nausea/Vomithing
- ■ 780.4 Dizzy/Lightheaded
- ☐ 386.11 Positional Vertigo
- ☐ Other _____

## MISC

- ■ 308.0 Anxiety
- ■ 300.4 Depression
- ■ 309.81 Post Traumatic Stress Disorder
- ■ 848.1 TMJ Sp/St
- ■ 524.60 TMJ Pain
- ■ 728.85 TMJ Myospasm
- ☐ 388.31 Tinnitus
- ☐ 401.1 Hypertension
- ☐ 250.0 Aggravation of Diabetes
- ☐ 781.9 Abnormal Posture 2ary to Trauma
- ☐ 788.30 Urinary Incontinence
- ☐ Other(s) _____
- ■ Disability to 6/15/08
- ■ Total ☐ Partial ☐ Limitations _____
- ☐ _____

1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AAA Los Angeles
Attn Sharon Moore
2601 S Figueroa Street H109
Los Angeles CA 90007

CARRIER

PICA ☐ | PICA ☐

| 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): [redacted]

| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | 3. PATIENT'S BIRTH DATE MM DD YY / SEX | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
|---|---|---|
| [redacted] | 11 05 1931 M ☐ F ☒ | [redacted] |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO INSURED | 7. INSURED'S ADDRESS (No., Street) |
| [redacted] | Self ☐ Spouse ☐ Child ☐ Other ☒ | |
| CITY: Newport Bch / STATE: CA | 8. PATIENT STATUS: Single ☐ Married ☐ Other ☒ | CITY: Fountain Valley / STATE: CA |
| ZIP CODE: 92663 / TELEPHONE (Include Area Code): ( 949) 233 9968 | Employed ☐ Full-Time Student ☐ Part-Time Student ☐ | ZIP CODE: 92708 / TELEPHONE (Include Area Code): ( 714) 968 5902 |
| 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) CA | 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: AAA Los Angeles |
| 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: Signature on file DATE: 05 09 2008

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: Signature on file

| 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 / MM DD YY TO |
|---|---|---|
| 04 23 2008 | | |
| 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. 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. 854 00
3. 780 89
2. 784 0
4. On File

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 04 30 2008 | 12 | N | 99349 | 1234 | 250 00 | 1 | N | NPI | 160989178[redacted] |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

Supplement

| 25. FEDERAL TAX I.D. NUMBER / SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) | 28. TOTAL CHARGE | 29. AMOUNT PAID | 30. BALANCE DUE |
|---|---|---|---|---|---|
| 33 0212635 ☐ ☒ | [redacted] | ☒ YES ☐ NO | $ 250 00 | $ 0 00 | $ 250 00 |

| 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.) | 32. SERVICE FACILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # ( 714) 962 7103 |
|---|---|---|
| [redacted] | | [redacted] Huntington Beach CA 92646 |
| SIGNED 05 09 2008 DATE | a. / b. | a. 1609891787 / b. |

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION