

APPENDIX C:

ANSWERS TO APPENDIX C CASE STUDIES

CASE C-1

1 TOWNSHIP MEMORIAL HOSPITAL		2 C1		3a PAT CNTL # 56139844		4 TYPE OF BILL 111	
700 SHADY ST				b MED REC # 659431896			
TOWNSHIP NY 12345				5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 0728XX THROUGH 0801XX	
555550700							
8 PATIENT NAME a				9 PATIENT ADDRESS a 63 PARK AVE			
b WILLIS NESTOR				b CAPITAL CITY			
		c NY		d 12345		e	
10 BIRTHDATE		11 SEX F		12 DATE 0728XX		13 ADMISSION HR 01	
14 TYPE 1		15 SRC 1		16 DHR 15		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACOT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37 OCCURRENCE SPAN THROUGH	
38 WILLIS NESTOR 63 PARK AVE CAPITAL CITY NY 12345		39 CODE 80		40 CODE 4		41 CODE	
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	ROOM BOARD SEMI	450.00		4	1800 00	0 00
2	260	IV THERAPY			4	1000 00	0 00
3	300	LAB			1	235 00	0 00
4	320	RADIOLOGY			1	250 00	0 00
5	900	RESPIRATORY SERVICES			4	400 00	0 00
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	0801XX	TOTALS	3685 00	0 00
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICAID				Y	Y	00:00	56 NPI 34343434
57 OTHER PRV. ID		58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME
		WILLIS NESTOR		18	322654921345		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
32191321							
66 DX 9		486	4928	30511	F	G	H
69 ADMIT DX 786.59		70 PATIENT REASON DX a		b	c	71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE CODE 87.44		a OTHER PROCEDURE CODE 0728XX		b	c	73	
75		76 ATTENDING NPI 1234567890		QUAL			
77 OPERATING NPI		LAST WELLS MD		FIRST PHIL			
78 OTHER NPI		LAST		FIRST			
79 OTHER NPI		LAST		FIRST			
80 REMARKS		81 CC a		b		c	
		b		c		d	

CASE C-2

1 CAPITAL CITY GENERAL HOSPITAL		2 C2		3a PAT CNTL # 6132198		4 TYPE OF BILL 111	
1000 CHERRY ST				b MED REC # ML18913			
CAPITAL CITY NY 12345				5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 1010XX THROUGH 1013XX	
8 PATIENT NAME a LYLES MELVIN		9 PATIENT ADDRESS a 2001 MEADOW RD					
b		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 051472		11 SEX M		12 DATE 1010XX		13 HR 20	
14 TYPE 1		15 SRC 1		16 DHR 07		17 STAT 01	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 CODE		36 OCCURRENCE SPAN FROM		37 THROUGH		38	
39 CODE 80		40 VALUE CODES AMOUNT 3		41 CODE		42 VALUE CODES AMOUNT	
38 LYLES MELVIN		2001 MEADOW RD		CAPITAL CITY NY 12345			
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	ROOM BOARD SEMI	400.00		3	1200 00	0 00
2	250	PHARMACY			8	375 00	0 00
3	260	IV THERAPY			2	850 00	0 00
4	300	LAB			5	450 00	0 00
5	320	RADIOLOGY			1	900 00	0 00
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	1013XX	TOTALS	3775 00	0 00
50 PAYER NAME BLUE CROSS BLUE SHIELD		51 HEALTH PLAN ID 87590		52 REL INFO Y	53 ASG BEN. Y	54 PRIOR PAYMENTS 00:00	
55 EST. AMOUNT DUE		56 NPI 12121212		57 OTHER PRV. ID			
58 INSURED'S NAME LYLES SHELBY		59 01		60 INSURED'S UNIQUE ID YYJ561319821		61 GROUP NAME	
62 INSURANCE GROUP NO. 025648		63 TREATMENT AUTHORIZATION CODES 846465315		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME GREEN LANDSCAPING CO	
66 DX 9		25042		58381		27800	
V653		V8532		F		G	
H		68		70 PATIENT REASON DX a		b	
71 PPS CODE c		72 ECI		a		b	
73		74 PRINCIPAL PROCEDURE CODE 8848		75 OTHER PROCEDURE CODE 1011XX		76 ATTENDING NPI 9876543210	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
76 ALRIGHT MD		77 ELBY		78		79	
79		80 REMARKS		81 CC a		b	
81 CC c		81 CC d		81 CC e		81 CC f	

CASE C-3

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 5555551000	2 C3		3a PAT CNTL # 646413		4 TYPE OF BILL 111																																																									
b MENDEZ EMILIO			b CAPITAL CITY			c NY																																																								
9 PATIENT ADDRESS 3009 RIVER RD			d 12345			e																																																								
10 BIRTHDATE 093084			11 SEX M			12 DATE 0607XX			13 HR			14 TYPE 17			15 SRC 1			16 DHR 7			17 STAT 11			18			19			20			21			22			23			24			25			26			27			28			29 ACOT STATE			30		
31 OCCURRENCE DATE A2			32 CODE 050371			33 OCCURRENCE DATE			34 CODE			35 OCCURRENCE DATE			36 CODE			37 OCCURRENCE DATE			38			39			40			41			42			43			44			45			46			47			48			49								
38 MENDEZ EMILIO 3009 RIVER RD CAPITAL CITY NY 12345			39 CODE 80			40 VALUE CODES AMOUNT 3			41 CODE			42 VALUE CODES AMOUNT			43 CODE			44 VALUE CODES AMOUNT			45			46			47			48			49			50			51			52			53			54			55			56			57					
42 REV.CD. 1 120			43 DESCRIPTION ROOM BOARD SEMI			44 HCPCS/RATE/HIPPS CODE 400.00			45 SERV. DATE			46 SERV. UNITS 3			47 TOTAL CHARGES 1200 00			48 NON-COVERED CHARGES 0 00			49			50			51			52			53			54			55			56			57																	
2 250			PHARMACY									7			400 00			0 00			58			59			60			61			62			63			64			65																				
3 260			IV THERAPY									3			900 00			0 00			66			67			68			69			70			71			72			73																				
4 300			LAB									6			700 00			0 00			74			75			76			77			78			79			80																							
5																		0 00			81			82			83			84			85			86			87			88																				
6																					89			90			91			92			93			94			95																							
7																					96			97			98			99			100			101			102																							
8																					103			104			105			106			107			108			109																							
9																					110			111			112			113			114			115			116																							
10																					117			118			119			120			121			122			123																							
11																					124			125			126			127			128			129			130																							
12																					131			132			133			134			135			136			137																							
13																					138			139			140			141			142			143			144																							
14																					145			146			147			148			149			150			151																							
15																					152			153			154			155			156			157			158																							
16																					159			160			161			162			163			164			165																							
17																					166			167			168			169			170			171			172																							
18																					173			174			175			176			177			178			179																							
19																					180			181			182			183			184			185			186																							
20																					187			188			189			190			191			192			193																							
21																					194			195			196			197			198			199			200																							
22																					201			202			203			204			205			206			207																							
23			001			PAGE 1 OF 1			CREATION DATE			0610XX			TOTALS			3200 00			0 00			208			209			210			211			212			213																							
50 PAYER NAME BLUE CROSS BLUE SHIELD			51 HEALTH PLAN ID 87590			52 REL INFO Y			53 ASG BEN. Y			54 PRIOR PAYMENTS 00:00			55 EST. AMOUNT DUE			56 NPI 1212121212			57 OTHER PRV. ID			214			215			216			217			218			219																							
58 INSURED'S NAME MENDEZ EMILIO			59 18			60 INSURED'S UNIQUE ID YY2156349873			61 GROUP NAME			62 INSURANCE GROUP NO. 252354			220			221			222			223			224			225			226			227			228																							
63 TREATMENT AUTHORIZATION CODES 5168431313			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME TOUGH GUYS GYM			229			230			231			232			233			234			235			236			237			238			239																							
66 DX 9			03810			5265			F			G			H			68			240			241			242			243			244			245			246																							
69 ADMIT DX 5265			70 PATIENT REASON DX a			b			c			71 PPS CODE 72 ECI			a			b			c			73			247			248			249			250			251																							
74 PRINCIPAL PROCEDURE CODE 9052			a OTHER PROCEDURE CODE 0607XX			b OTHER PROCEDURE CODE			c OTHER PROCEDURE CODE			75			76 ATTENDING ALRIGHT MD			NPI 9876543210			QUAL			77			252			253			254			255			256																							
c OTHER PROCEDURE CODE			d OTHER PROCEDURE CODE			e OTHER PROCEDURE CODE			78			79 OPERATING ELBY			NPI			QUAL			80			257			258			259			260			261			262																							
80 REMARKS			81 CC a			b			c			78 OTHER LAST			NPI			QUAL			82			263			264			265			266			267			268																							
			b			c			79 OTHER LAST			NPI			QUAL			83			269			270			271			272			273			274			275																							
			c			d			79 OTHER LAST			NPI			QUAL			84			276			277			278			279			280			281			282																							
			d						79 OTHER LAST			NPI			QUAL			85			283			284			285			286			287			288			289																							

CASE C-4

1 COUNTY COMMUNITY HOSPITAL 1600 CLOVER ST CAPITAL CITY NY 12345 5555551600		2 C4		3a PAT CNL # 564321 b MED REC # 005332496		4 TYPE OF BILL 111	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 70707070		6 STATEMENT COVERS PERIOD FROM 1122XX THROUGH 1124XX	
b JANOVICH HAROLD		b TOWNSHIP		c NY		d 12345	
10 BIRTHDATE 121271		11 SEX M		12 DATE 1122XX		13 HR 18	
14 TYPE 1		15 SRC 7		16 DHR 17		17 STAT 01	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 OCCURRENCE SPAN FROM		37 THROUGH		38	
38 JANOVICH HAROLD 532 CREEK ST TOWNSHIP NY 12345		39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT b 2		41 VALUE CODES AMOUNT c	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	ROOM BOARD SEMI	400.00		2	800	00
2	250	PHARMACY			5	400	00
3	260	IV THERAPY			2	950	00
4	270	MED SURG SUPPLIES			1	500	00
5	300	LAB			2	300	00
6	320	RADIOLOGY			1	650	00
7	360	OR SERVICES			1	1200	00
8	370	ANESTHESIA			1	600	00
23	001	PAGE 1 OF 1	CREATION DATE	1124XX	TOTALS	5400	00
50 PAYER NAME AETNA		51 HEALTH PLAN ID 06599		52 REL INFO Y		53 ASG BEN. Y	
54 PRIOR PAYMENTS 00		55 EST. AMOUNT DUE 00		56 NPI 57		67676767	
58 INSURED'S NAME JANOVICH HAROLD		59 18		60 INSURED'S UNIQUE ID 65321313		61 GROUP NAME 62 INSURANCE GROUP NO. 97390	
63 TREATMENT AUTHORIZATION CODES 10564598		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME BUY N SAVE GROCERS LTD			
66 DX 9		5409		F		G H 68	
69 ADMIT DX 78903		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 4709		a DATE 1122XX		b OTHER PROCEDURE CODE 8876		c DATE 1122XX	
75		76 ATTENDING NPI 0123456789		77 OPERATING NPI		73	
78 OTHER NPI		79 OTHER NPI		QUAL		FIRST	
80 REMARKS		81CC a		b		c	
		b		c		d	

CASE C-5

1 TOWNSHIP MEMORIAL HOSPITAL		2 C5		3a PAT CNTL # 594313		4 TYPE OF BILL 111	
700 SHADY ST				b MED REC # RK654142			
TOWNSHIP NY 12345				5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 1212XX THROUGH 1214XX	
555550700							
8 PATIENT NAME a			9 PATIENT ADDRESS a 14 BERRY LN				
b KEDAR RAMESH			b TOWNSHIP			c NY d 12345 e	
10 BIRTHDATE 030767		11 SEX M		12 DATE 1212XX		13 HR 00	
14 TYPE 1		15 SRC 1		16 DHR 10		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE	
34 CODE		35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE	
38 KEDAR RAMESH		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
14 BERRY LN		a 80		2			
TOWNSHIP NY 12345		b		c		d	
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	ROOM BOARD SEMI	400.00		2	800 00	0 00
2	250	PHARMACY			3	375 00	0 00
3	260	IV THERAPY			3	1200 00	0 00
4	300	LAB			6	450 00	0 00
5	320	RADIOLOGY			1	1000 00	0 00
6	730	EKG			1	150 00	0 00
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	1212XX	TOTALS	3975 00	0 00
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	
A HEALTH AMERICA		B 87431		Y	Y	C 00:00	
58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
A KEDAR RAMESH		B 18	C 65432678		D		E 6649
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME	
A 54577888			B			C WHOLESALE ELECTRONICS INC	
66 DX	41519	30000	4019		F	G	H
69 ADMIT DX	786.05	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE CODE	9215	DATE	1212XX	OTHER PROCEDURE CODE	8872	DATE	1212XX
75	OTHER PROCEDURE CODE	8952	DATE	1212XX	76 ATTENDING NPI	0246802468	QUAL
c	OTHER PROCEDURE CODE	d	OTHER PROCEDURE CODE	e	OTHER PROCEDURE CODE	77 OPERATING NPI	QUAL
80 REMARKS		81 CC	a	b	78 OTHER NPI	QUAL	79 OTHER NPI
		b			LAST	FIRST	QUAL
		c			LAST	FIRST	QUAL
		d			LAST	FIRST	QUAL

CASE C-6

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 123452222 5555551000		2 C6		3a PAT CNTL # 4616549 b MED REC # ZA16836401		4 TYPE OF BILL 0111	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 75757575		6 STATEMENT COVERS PERIOD FROM 0901XX THROUGH 0905XX	
b ZBEGAN ARTHUR		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 041139		11 SEX M		12 DATE 0901XX		13 HR 02	
14 TYPE 1		15 SRC 7		16 DHR 11		17 STAT 01	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38	
38 ZBEGAN ARTHUR 9832 GRASS RD CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT b 4		41 VALUE CODES AMOUNT c	
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0210	CORONARY CARE	650.00		4	2600 00	0 00
2	0250	PHARMACY			5	425 00	0 00
3	0260	IV THERAPY			4	1200 00	0 00
4	0270	MED SURG SUPPLIES			1	800 00	0 00
5	0300	LAB			5	450 00	0 00
6	0360	OR SERVICES			1	2300 00	0 00
7	0370	ANESTHESIA			1	675 00	0 00
8	0730	EKG			1	175 00	0 00
23	0001	PAGE 1 OF 1	CREATION DATE	0905XX	TOTALS	8625 00	0 00
50 PAYER NAME A MEDICARE		51 HEALTH PLAN ID B 62541		52 REL INFO C Y		53 ASG BEN. D Y	
54 PRIOR PAYMENTS E 00 00		55 EST. AMOUNT DUE F		56 NPI G 12121212		57 OTHER PRV. ID H	
58 INSURED'S NAME A ZBEGAN ARTHUR		59 B 18		60 INSURED'S UNIQUE ID C 629417113A		61 GROUP NAME D	
62 INSURANCE GROUP NO. E		63 TREATMENT AUTHORIZATION CODES A 5463664535		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C	
66 DX 9		41181		41400		40200	
67		V4581		F		G H	
69 ADMIT DX 4139		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 3612		a OTHER PROCEDURE CODE 0902XX		b OTHER PROCEDURE CODE 8944		c OTHER PROCEDURE CODE 0901XX	
75		76 ATTENDING NPI 0246802468		77 OPERATING NPI		78 OTHER NPI	
79 OTHER NPI		LAST HART MD		FIRST IVA		QUAL	
80 REMARKS		81CC a		b		c	
82		83		84		85	
86		87		88		89	
90		91		92		93	

CASE C-7

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY STREET CAPITAL CITY NY 12345 555551000		2		3a PAT CNTL # b MED REC # 0063259 000233168		4 TYPE OF BILL 0111	
8 PATIENT NAME a		9 PATIENT ADDRESS a		4 S. ORANGE WAY			
b MANGINO RITA		b TOWNSHIP		c NY		d 12345	
10 BIRTHDATE 02081957		11 SEX F		12 DATE 0114XX		13	
13 HR		14 TYPE		15 SRC		16 DHR	
17 STAT		18		19		20	
21		22		23		24	
25		26		27		28	
29 ACDT		30		STATE			
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35		36		37			
38 MANGINO, RITA 4 S. ORANGE WAY, CAPITAL CITY NY 12345		39 CODE		40 VALUE CODES AMOUNT		41 CODE	
		a 80		2			
		b					
		c					
		d					
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	120	ROOM/BOARD/SEMI	450.00	0114XX	2	900 00	0 00
2	320	RADIOLOGY		0114XX	2	500 00	0 00
3	300	LAB		0114XX	1	105 00	0 00
4	260	IV THERAPY		0114XX	2	820 00	0 00
5	270	MED/SURG SUPPLIES		0114XX	5	400 00	0 00
6	250	PHARMACY		0114XX	1	375 00	0 00
7	900	RESPIRATORY SERVICES		0114XX	3	600 00	0 00
8				0114XX	3		
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1	CREATION DATE	0116XX	TOTALS	3700 00	0 00
50 PAYER NAME AETNA		51 HEALTH PLAN ID 21084		52 REL INFO Y	53 ASG BEN. Y	54 PRIOR PAYMENTS 00:00	
55 EST. AMOUNT DUE		56 NPI 1212121212		57 OTHER PRV. ID			
58 INSURED'S NAME MANGINO, BRUCE		59 01		60 INSURED'S UNIQUE ID 4783900		61 GROUP NAME	
62 INSURANCE GROUP NO. 493		63 TREATMENT AUTHORIZATION CODES 5331648		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME CRITTER'S CAMPUS	
66 DX 9		5180		493.92		F G H	
69 ADMIT DX 493.92		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 34.91		DATE 0114XX		75 OTHER PROCEDURE CODE 87.44		DATE 0114XX	
76 ATTENDING NPI 1234567890		QUAL		77 OPERATING NPI		QUAL	
LAST WELLS MD		FIRST PHIL		LAST		FIRST	
78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
LAST		FIRST		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		d					

CASE C-8

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 123452222 5555551000		2 C8		3a PAT CNL # 198761 b MED REC # 00025643189		4 TYPE OF BILL 0111	
5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 0814XX THROUGH 0818XX		7			
8 PATIENT NAME a GREER DOROTHY		9 PATIENT ADDRESS a 777 SYCAMORE CIR					
b		c CAPITAL CITY				d NY	
e 12345							
10 BIRTHDATE 100249		11 SEX M		12 DATE 0814XX		13 HR 09	
14 TYPE 1		15 SRC 7		16 DHR 14		17 STAT 01	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	
38 GREER DOROTHY 777 SYCAMORE CIR CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT b 4		41 VALUE CODES AMOUNT c	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0210	CORONARY CARE	600.00		4	2400 00	0 00
2	0250	PHARMACY			5	350 00	0 00
3	0260	IV THERAPY			4	1000 00	0 00
4	0270	MED SURG SUPPLIES			1	900 00	0 00
5	0300	LAB			5	600 00	0 00
6	0360	OR SERVICES			1	1950 00	0 00
7	0370	ANESTHESIA			1	700 00	0 00
8	0730	EKG			1	150 00	0 00
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1	CREATION DATE	0818XX	TOTALS	8050 00	0 00
50 PAYER NAME A MEDICARE		51 HEALTH PLAN ID B 62541		52 REL INFO C Y		53 ASG BEN. D Y	
54 PRIOR PAYMENTS E 00 00		55 EST. AMOUNT DUE F		56 NPI G 1212121212		57 OTHER PRV. ID H	
58 INSURED'S NAME A GREER DOROTHY		59 B 18		60 INSURED'S UNIQUE ID C 629417113A		61 GROUP NAME D	
62 INSURANCE GROUP NO. E		63 TREATMENT AUTHORIZATION CODES A 198131332		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C	
66 DX 9 99601		7802		F		G H	
69 ADMIT DX 7802		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 0050		DATE 0814XX		OTHER PROCEDURE CODE 8944		DATE 0814XX	
75 OTHER PROCEDURE CODE 8872		DATE 0814XX		76 ATTENDING NPI 0246802468		QUAL	
77 OPERATING NPI		DATE		LAST HART MD		FIRST IVA	
78 OTHER NPI		DATE		LAST		FIRST	
79 OTHER NPI		DATE		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		d					

CASE C-9

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345222 555551000		2 C9		3a PAT CNTL # 578877 b MED REC # 654943233		4 TYPE OF BILL 111	
5 FED. TAX. NO. 7575757				6 STATEMENT COVERS PERIOD FROM 0311XX THROUGH 0315XX		7	
8 PATIENT NAME a		9 PATIENT ADDRESS a 934 SMITHFIELD ST					
b MOORE VIRGINIA		b CAPITAL CITY				c NY d 12345 e	
10 BIRTHDATE 012744		11 SEX F		12 DATE 0311XX		13 HR 17	
14 TYPE 2		15 SRC 1		16 DHR 14		17 STAT 62	
31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE		34 CODE	
35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE		38 CODE	
39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT b 4		41 VALUE CODES AMOUNT c		42	
43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE		46 SERV. UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
1	120	ROOM BOARD SEMI	650.00		4	2600 00	0 00
2	250	PHARMACY			5	400 00	0 00
3	260	IV THERAPY			4	1200 00	0 00
4	270	MED SURG SUPPLIES			1	1200 00	0 00
5	300	LAB			2	400 00	0 00
6	320	RADIOLOGY			1	250 00	0 00
7	360	OR SERVICES			1	2600 00	0 00
8	370	ANESTHESIA			1	800 00	0 00
9	730	EKG			1	175 00	0 00
23	001	PAGE 1 OF 1	CREATION DATE	0315XX	TOTALS	9625 00	0 00
50 PAYER NAME A MEDICAID		51 HEALTH PLAN ID B 92101		52 REL INFO C Y	53 ASG BEN D Y	54 PRIOR PAYMENTS E 00:00	
55 EST. AMOUNT DUE F		56 NPI G 12121212		57 OTHER PRV. ID H			
58 INSURED'S NAME A MOORE VIRGINIA		59 B 18	60 INSURED'S UNIQUE ID C 629417113972		61 GROUP NAME D		62 INSURANCE GROUP NO. E
63 TREATMENT AUTHORIZATION CODES A 519843131		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C			
66 DX 9 82020		73110		71509		4019	
69 ADMIT DX 82020		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 8151		DATE 0312XX		OTHER PROCEDURE CODE 8826		DATE 0311XX	
75 OTHER PROCEDURE CODE 8952		DATE 0312XX		76 ATTENDING NPI 1357613579		QUAL	
77 OPERATING NPI		DATE		LAST TISS MD		FIRST ARTHUR	
80 REMARKS		81 CC a		b		c	
		82 OTHER NPI		QUAL		LAST	
		79 OTHER NPI		QUAL		LAST	

CASE C-10

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 123452222 5555551000		2 C10		3a PAT CNTRL # b MED REC # 015356 AK45329		4 TYPE OF BILL 0111	
8 PATIENT NAME a KIM ALBERT		9 PATIENT ADDRESS a 601 SUNFLOWER DR		c NY		d 12345	
10 BIRTHDATE 060230		11 SEX M		12 DATE 0403XX		13 HR 16	
14 TYPE 1		15 SRC 7		16 DHR 12		17 STAT 03	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
38 KIM ALBERT 601 SUNFLOWER DR CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT 4		41 VALUE CODES AMOUNT	
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0210	CORONARY CARE	650.00		4	2600 00	0 00
2	0250	PHARMACY			5	375 00	0 00
3	0260	IV THERAPY			4	1000 00	0 00
4	0270	MED SURG SUPPLIES			1	400 00	0 00
5	0300	LAB			2	220 00	0 00
6	0320	RADIOLOGY			2	550 00	0 00
7	0730	EKG			1	150 00	0 00
8	0900	RESPIRATORY SERVICES			1	400 00	0 00
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1	CREATION DATE	0407XX	TOTALS	5695 00	0 00
50 PAYER NAME A MEDICARE		51 HEALTH PLAN ID 62541		52 REL INFO Y		53 ASG BEN. Y	
54 PRIOR PAYMENTS 00 00		55 EST. AMOUNT DUE		56 NPI 57 OTHER PRV. ID		1212121212	
58 INSURED'S NAME A KIM ALBERT		59 18		60 INSURED'S UNIQUE ID 629417113A		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES A 646819900		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9		42001		4280		F G H	
69 ADMIT DX 7865		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 3491		75 OTHER PROCEDURE CODE 0405XX		76 ATTENDING NPI 0246802468		73 QUAL	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		FIRST HART MD IVA	
80 REMARKS		81 CC a		b		c	
		c		d		FIRST	

CASE C-11

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 5555551000		2 C11		3a PAT CNTL # 213652 b MED REC # OM24965		4 TYPE OF BILL 131	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 0823XX THROUGH 0823XX	
b MARSELLE OLIVIA		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 102975		11 SEX F		12 DATE 0823XX		13 HR 7	
14 TYPE 01		15 SRC 16 DHR		17 STAT		18 19 20 21	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38	
38 MARSELLE OLIVIA 4142 VALLEY RD CAPITAL CITY NY 12345				39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT	
				41 CODE		42	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	300	LAB	36415	0823XX	1	20 00	0 00
2	301	LAB	80053	0823XX	2	230 00	0 00
3	305	LAB	85025	0823XX	1	25 00	0 00
4	450	ER		0823XX	1	350 00	0 00
23	001	PAGE 1 OF 1	CREATION DATE	0823XX	TOTALS	625 00	0 00
50 PAYER NAME MEDICAID		51 HEALTH PLAN ID 92101		52 REL INFO Y		53 ASG BEN Y	
54 PRIOR PAYMENTS 00:00		55 EST. AMOUNT DUE		56 NPI 1212121212		57 OTHER PRV. ID	
58 INSURED'S NAME MARSELLE OLIVIA		59 18		60 INSURED'S UNIQUE ID 0564616665659		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 DX 9604		49322		F		G H	
69 ADMIT DX		70 PATIENT REASON DX 78701a		b		c	
71 PPS CODE		72 ECI E930a		a		b c	
73		74 PRINCIPAL PROCEDURE DATE		b OTHER PROCEDURE DATE		c OTHER PROCEDURE DATE	
75		76 ATTENDING NPI 1471471471		QUAL		77	
77 OPERATING NPI		QUAL		78 OTHER NPI		QUAL	
79 OTHER NPI		QUAL		FIRST		LAST	
80 REMARKS		81 CC a		b		c	
		d		FIRST		LAST	

CASE C-12

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 5555551000		2 C12		3a PAT CNTL # 869244 b MED REC # AR3461		4 TYPE OF BILL 131	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 0518XX THROUGH 0518XX	
b RODRIGUEZ ANTONIO		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 042854		11 SEX M		12 DATE 0518XX		13 HR 1	
14 TYPE 1		15 SRC 01		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE A2		32 OCCURRENCE DATE 073059		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
38 RODRIGUEZ ANTONIO 32 PLANK CIR CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	260	IV THERAPY		0518XX	1	400	00
2	270	MED SURG SUPPLIES		0518XX	1	500	00
3	500	AMBUL SURG	45384	0518XX	1	2200	00
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	0518XX	TOTALS	3100	00
50 PAYER NAME A BLUE CROSS BLUE SHIELD		51 HEALTH PLAN ID 87590		52 REL INFO Y		53 ASG BEN. Y	
54 PRIOR PAYMENTS 00		55 EST. AMOUNT DUE 00		56 NPI 57		1212121212	
58 INSURED'S NAME A RODRIGUEZ CASSANDRA		59 01		60 INSURED'S UNIQUE ID YY294004954		61 GROUP NAME	
62 INSURANCE GROUP NO. 727524		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME RICHIE RICH BANK OF USA	
66 DX 9		67		F		G H 68	
69 ADMIT DX		70 PATIENT REASON DX a		b		c	
71 PPS CODE		72 ECI E9304		b		c	
73		74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE	
75		c OTHER PROCEDURE CODE		d OTHER PROCEDURE CODE		e OTHER PROCEDURE CODE	
76 ATTENDING NPI 0123456789		QUAL		LAST MENDS MD		FIRST MANNIE	
77 OPERATING NPI		QUAL		LAST		FIRST	
78 OTHER NPI		QUAL		LAST		FIRST	
79 OTHER NPI		QUAL		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		d					

CASE C-13

1 COUNTY COMMUNITY HOSPITAL 1600 CLOVER ST CAPITAL CITY NY 12345		2		3a PAT CNTRL # b MED REC #		04698 RP1297		4 TYPE OF BILL 131																															
5 FED. TAX. NO. 707070707				6 STATEMENT COVERS PERIOD FROM 1125XX		7 THROUGH 1125XX																																	
8 PATIENT NAME a			9 PATIENT ADDRESS a																																				
b PAUL RANDALL			b CAPITAL CITY				c NY		d 12345																														
10 BIRTHDATE 120959		11 SEX M		12 DATE 1125XX		13 HR 1		16 DHR 01		17 STAT 01		18		19		20		21		22		23		24		25		26		27		28		29 ACDT STATE		30			
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH		38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42		43		44		45		46		47		48		49			
a PAUL RANDALL 231 BOSTON AVE APT 5 CAPITAL CITY NY 12345										a		b		c		d		e		f		g		h		i		j		k		l		m		n		o	
42 REV. CD.		43 DESCRIPTION			44 HCPCS/RATE/HIPPS CODE			45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																							
1 250		PHARMACY						1125XX		1		90 00		0 00		1																							
2 260		IV THERAPY						1125XX		1		575 00		0 00		2																							
3 320		RADIOLOGY			74170			1125XX		1		850 00		0 00		3																							
4																4																							
5																5																							
6																6																							
7																7																							
8																8																							
9																9																							
10																10																							
11																11																							
12																12																							
13																13																							
14																14																							
15																15																							
16																16																							
17																17																							
18																18																							
19																19																							
20																20																							
21																21																							
22																22																							
23		001 PAGE 1 OF 1			CREATION DATE			1125XX		TOTALS		1515 00		0 00		23																							
50 PAYER NAME AETNA				51 HEALTH PLAN ID 06599				52 REL INFO Y		53 ASG BEN. Y		54 PRIOR PAYMENTS 00:00		55 EST. AMOUNT DUE		56 NPI 6767676		57 OTHER PRV. ID																					
58 INSURED'S NAME PAUL RANDALL				59 18		60 INSURED'S UNIQUE ID YY204753589				61 GROUP NAME				62 INSURANCE GROUP NO.																									
63 TREATMENT AUTHORIZATION CODES						64 DOCUMENT CONTROL NUMBER						65 EMPLOYER NAME RANDYS GAMING STOP																											
66 DX 9		78930		F		G		H		68																													
69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		a		b		c		73																			
74 PRINCIPAL PROCEDURE CODE		DATE		a OTHER PROCEDURE CODE		DATE		b OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		987654321		QUAL																					
														LAST		ALRIGHT MD		FIRST		ELBY																			
c OTHER PROCEDURE CODE		DATE		d OTHER PROCEDURE CODE		DATE		e OTHER PROCEDURE CODE		DATE				77 OPERATING NPI				QUAL																					
														LAST				FIRST																					
80 REMARKS				81 CC		a		b		78 OTHER NPI				QUAL				LAST		FIRST																			
																		LAST		FIRST																			
																		79 OTHER NPI		QUAL																			
																		LAST		FIRST																			

CASE C-14

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 5555551000		2 C14		3a PAT CNTL # 462013 b MED REC # MB8020		4 TYPE OF BILL 131	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 0916XX THROUGH 0916XX	
b BISHOP MEGAN		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 103162		11 SEX F		12 DATE OF ADMISSION 0916XX		13 HR 1	
14 TYPE 1		15 SRC 01		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 CODE		33 OCCURRENCE DATE	
34 CODE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 THROUGH	
38 BISHOP MEGAN 5834 CLIFF ST CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	320	RADIOLOGY	77057	0916XX	1	775	00
2	972	RADIOLOGIST		0916XX	1	100	00
3					1		
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	0916XX	TOTALS	875	00
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE		56 NPI		1212121212			
A BLUE CROSS BLUE SHIELD		87590		Y	Y	00:00	
B				OTHER PRV. ID			
C							
58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
A BISHOP MEGAN		18	YYJ846168930				688112
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A				VIDEOS PLUS			
B							
C							
66 DX		67		68			
9				F		G H	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		73	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		75	
c OTHER PROCEDURE CODE		d OTHER PROCEDURE DATE		e OTHER PROCEDURE DATE			
80 REMARKS		81 CC a		82 OTHER b		83 QUAL	
		b				FIRST	
		c				LAST	
		d				FIRST	
				78 OTHER		NPI QUAL	
				LAST		FIRST	
				79 OTHER		NPI QUAL	
				LAST		FIRST	

CASE C-15

1 COUNTY COMMUNITY HOSPITAL					2 C15					3a PAT CNTRL # 665090					4 TYPE OF BILL 131												
1600 CLOVER ST										b MED REC # PV7539																	
CAPITAL CITY NY 12345										5 FED. TAX. NO. 7070707		6 STATEMENT COVERS PERIOD FROM 0619XX			7 THROUGH 0619XX												
555551600																											
8 PATIENT NAME a					9 PATIENT ADDRESS a					988 MILL RUN RD																	
b VLAH PATRICIA					b TOWNSHIP					c NY					d 12345												
10 BIRTHDATE		11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30						
021100		F	0619XX		1		01																				
31 OCCURRENCE DATE		32 CODE		OCCURRENCE DATE		33 CODE		OCCURRENCE DATE		34 CODE		OCCURRENCE DATE		35 CODE		OCCURRENCE SPAN FROM		THROUGH		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37	
38 VLAH SUZANNE					988 MILL RUN RD										39 VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT				
988 MILL RUN RD					TOWNSHIP					NY					12345												
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49													
1 250		PHARMACY				0619XX		1		150 00		0 00		1													
2 260		IV THERAPY				0619XX		1		750 00		0 00		2													
3 270		MED SURG SUPPLIES				0619XX		1		400 00		0 00		3													
4 370		ANESTHESIA				0619XX		1		700 00		0 00		4													
5 500		AMBUL SURG		42820		0619XX		1		1500 00		0 00		5													
6														6													
7														7													
8														8													
9														9													
10														10													
11														11													
12														12													
13														13													
14														14													
15														15													
16														16													
17														17													
18														18													
19														19													
20														20													
21														21													
22														22													
23 001		PAGE 1 OF 1		CREATION DATE		0619XX		TOTALS		3500 00		0 00		23													
50 PAYER NAME			51 HEALTH PLAN ID			52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV. ID													
A AETNA			06599			Y	Y	00:00				6767676		A													
B														B													
C														C													
58 INSURED'S NAME			59	60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.																	
A VLAH SUZANNE			19	6561946						649104																	
B																											
C																											
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME																					
A						CUTS N CURLS SALON																					
B																											
C																											
66 DX		47402	F	G	H	68																					
9																											
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73																	
74 PRINCIPAL PROCEDURE CODE	DATE	a	OTHER PROCEDURE CODE	DATE	b	OTHER PROCEDURE CODE	DATE	75	76 ATTENDING NPI 0123456789	QUAL																	
									LAST MENDE MD	FIRST MANNIE																	
c	OTHER PROCEDURE CODE	DATE	d	OTHER PROCEDURE CODE	DATE	e	OTHER PROCEDURE CODE	DATE	77 OPERATING NPI	QUAL																	
									LAST	FIRST																	
80 REMARKS			81CC a						78 OTHER NPI	QUAL																	
			b						LAST	FIRST																	
			c						79 OTHER NPI	QUAL																	
			d						LAST	FIRST																	

CASE C-16

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 555551000		2 C16		3a PAT CNTRL # 925259 b MED REC # BC69281		4 TYPE OF BILL 131	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 75757575		6 STATEMENT COVERS PERIOD FROM 1101XX THROUGH 1101XX	
b CHUNG BRYSON		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 012197		11 SEX M		12 DATE 1101XX		13 HR 7	
14 TYPE 01		15 SRC 16 DHR		17 STAT		18 19 20 21	
31 OCCURRENCE DATE A2 042878		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38	
38 CHUNG MELISSA 205 GLASS RD CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	250	PHARMACY		1101XX	1	75 00	0 00
2	300	LAB	36415	1101XX	1	20 00	0 00
3	301	LAB	80053	1101XX	1	250 00	0 00
4	305	LAB	85025	1101XX	1	30 00	0 00
5	450	ER		1101XX	1	350 00	0 00
23	001	PAGE 1 OF 1	CREATION DATE	0619XX	TOTALS	725 00	0 00
50 PAYER NAME A HEALTH AMERICA		51 HEALTH PLAN ID B 62400		52 REL INFO C Y		53 ASG BEN. D Y	
54 PRIOR PAYMENTS E 00 00		55 EST. AMOUNT DUE		56 NPI F 12121212		57 OTHER PRV. ID	
58 INSURED'S NAME A CHUNG MICHAEL		59 B 43		60 INSURED'S UNIQUE ID C 4684646		61 GROUP NAME D	
62 INSURANCE GROUP NO. E 5215		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME F CUTS N CURLS SALON	
66 DX G 4878		67		68		69	
69 ADMIT DX H 9		70 PATIENT REASON DX I a		71 PPS CODE J b		72 ECI K c	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		75	
c OTHER PROCEDURE CODE		d OTHER PROCEDURE DATE		e OTHER PROCEDURE DATE		76 ATTENDING NPI 1471471471	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
80 REMARKS		81 CC a		b		c	
		c		d		LAST LOTTS MD FIRST KAREN	
						LAST KAREN FIRST	
						LAST FIRST	
						QUAL	
						QUAL	
						QUAL	
						QUAL	

CASE C-17

1 TOWNSHIP MEMORIAL HOSPITAL		2 C17		3a PAT CNTL # 728438		4 TYPE OF BILL 0131	
700 SHADY ST				b MED REC # KL693321			
CAPITAL CITY NY 12345				5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 0106XX THROUGH 0106XX	
8 PATIENT NAME		9 PATIENT ADDRESS					
a LOMBARDO KEITH		b TOWNSHIP		c NY		d 12345	
10 BIRTHDATE 051333		11 SEX M		12 DATE 0106XX		13 HR 1	
14 TYPE 1		15 SRC 01		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
a A2		042878					
38 LOMBARDO KEITH		174 JEFFERSON ST		TOWNSHIP		NY 12345	
39 CODE		40 CODE		41 CODE		42	
a		b		c		d	
43		44		45		46	
47		48		49		50	
1 0320 RADIOLOGY		76770		0106XX		1 300 00	
2 0972 RADIOLOGIST				0106XX		1 125 00	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23 0001		PAGE 1 OF 1		CREATION DATE		0106XX TOTALS 425 00 0 00	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A MEDICARE		15877		Y Y		54 PRIOR PAYMENTS 00:00	
B						55 EST. AMOUNT DUE	
C						56 NPI 34343434	
58 INSURED'S NAME		59		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A LOMBARDO KEITH		18		649331304A			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A							
B							
C							
66 DX 9		5920		F		G H 68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		73	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		75	
76 ATTENDING NPI 1234567890		QUAL		FIRST PHIL			
LAST WELLS MD							
77 OPERATING NPI		QUAL		FIRST			
LAST							
78 OTHER NPI		QUAL		FIRST			
LAST							
79 OTHER NPI		QUAL		FIRST			
LAST							
80 REMARKS		81 CC a		b		c	
		d					

CASE C-18

1 TOWNSHIP MEMORIAL HOSPITAL		2 C18		3a PAT CNL # 210158		4 TYPE OF BILL 131	
700 SHADY ST				b MED REC # TC11720			
TOWNSHIP NY 12345				5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 0821XX THROUGH 0821XX	
5555550700							
8 PATIENT NAME a		9 PATIENT ADDRESS a 55 LOCKWOOD DR					
b CLARK TYRONE		b TOWNSHIP				c NY d 12345 e	
10 BIRTHDATE 061580		11 SEX M		12 DATE 0821XX		13 HR 7	
14 TYPE 01		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
a A2 042878							
b							
38 CLARK TYRONE		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
55 LOCKWOOD DR		a		b		c	
TOWNSHIP NY 12345		d		e		f	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 250		PHARMACY				0821XX 1 50 00	
2 450		ER				0821XX 1 275 00	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23 001		PAGE 1 OF 1		CREATION DATE 0821XX		TOTALS 325 00 0 00	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN.	
A MEDICAID		43062		Y Y		54 PRIOR PAYMENTS 00 00	
B						55 EST. AMOUNT DUE	
C						56 NPI 34343434	
58 INSURED'S NAME		59		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A CLARK TYRONE		18		498481614			
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A							
B							
C							
66 DX 9		67		F		G H 68	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		73	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		75	
76 ATTENDING NPI 1471471471		QUAL		77 OPERATING NPI		QUAL	
LAST LOTTS MD		FIRST KAREN		LAST		FIRST	
78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
LAST		FIRST		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		d					

CASE C-19

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345222 555551000		2 C19		3a PAT CNTL # 319654 b MED REC # DH40195		4 TYPE OF BILL 0131	
8 PATIENT NAME a		9 PATIENT ADDRESS a		5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 1125XX THROUGH 1125XX	
b HUNT DAWN		b CAPITAL CITY		c NY		d 12345	
10 BIRTHDATE 092143		11 SEX F		12 DATE 1125XX		13 HR 7	
14 TYPE 01		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 CODE 1125XX		33 OCCURRENCE DATE	
34 CODE 01		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 THROUGH	
38 HUNT DAWN 46 HARLEY DR CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0320	RADIOLOGY	73090	1125XX	1	200 00	0 00
2	0320	RADIOLOGY	73100	1125XX	1	200 00	0 00
3	0450	ER		1125XX	1	300 00	0 00
4	0700	CASTING	29075	1125XX	1	95 00	0 00
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1	CREATION DATE	1125XX	TOTALS	795 00	0 00
50 PAYER NAME A MEDICARE		51 HEALTH PLAN ID B 62541		52 REL INFO C Y	53 ASG BEN D Y	54 PRIOR PAYMENTS E 00:00	
55 EST. AMOUNT DUE F		56 NPI G 12121212		57 OTHER PRV. ID H		58	
59 HUNT DAWN		60 INSURED'S UNIQUE ID B 18		61 GROUP NAME C 5328651498A		62 INSURANCE GROUP NO. D	
63 TREATMENT AUTHORIZATION CODES A		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C			
66 DX 9 81344		67		68		69	
70 PATIENT REASON DX 7295 a		71 PPS CODE b		72 ECI E8809 a		73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI 1471471471		77 QUAL	
78 LAST LOTT MD		79 FIRST KAREN		80 OPERATING NPI		81 QUAL	
82 LAST		83 FIRST		84 OTHER NPI		85 QUAL	
86 LAST		87 FIRST		88 OTHER NPI		89 QUAL	
90 LAST		91 FIRST		92 OTHER NPI		93 QUAL	
94 LAST		95 FIRST		96 OTHER NPI		97 QUAL	
98 LAST		99 FIRST		100 OTHER NPI		101 QUAL	
102 LAST		103 FIRST		104 OTHER NPI		105 QUAL	

CASE C-20

1 TOWNSHIP MEMORIAL HOSPITAL		2 C20		3a PAT CNTL # 751259		4 TYPE OF BILL 0131	
700 SHADY ST				b MED REC # JM820135			
TOWNSHIP NY 123452222				5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 0720XX THROUGH 0720XX	
5555550700							
8 PATIENT NAME a		9 PATIENT ADDRESS a 388 ATLANTIC AVE					
b MASTERS JENNA		b TOWNSHIP				c NY d 12345 e	
10 BIRTHDATE 031250		11 SEX F		12 DATE 0720XX		13 HR 1	
14 TYPE 1		15 SRC 01		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	
38 MASTERS JENNA		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
388 ATLANTIC AVE							
TOWNSHIP NY 12345							
42 REV.CD.		43 DESCRIPTION		44 HCPCS/RATE/HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1	0250	PHARMACY			0720XX	1	175 00
2	0260	IV THERAPY			0720XX	1	825 00
3	0270	MED SURG SUPPLIES			0720XX	1	450 00
4	0300	LAB			0720XX	1	375 00
5	0310	LAB PATH			0720XX	1	300 00
6	0370	ANESTHESIA			0720XX	1	750 00
7	0500	AMBUL SURG		38510	0720XX	1	1700 00
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1		CREATION DATE	0720XX	TOTALS	4575 00
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A MEDICARE		15877		Y	Y	00 00	56 NPI 3434343434
B							57 OTHER
C							PRV. ID
58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
A MASTERS JENNA		18	853614253A				
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
A							
B							
C							
66 DX 9		7856		F		G	H
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		75	
76 ATTENDING NPI 0123456789		QUAL		77 OPERATING NPI		QUAL	
LAST MENDS MD		FIRST MANNIE		LAST		FIRST	
78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
LAST		FIRST		LAST		FIRST	
80 REMARKS		81 CC a		b		c	
		d					

