PROVIDER ID: _____

PROVIDER NAME: _____

HOST NAME: _____

HOST ID: _____

PATIENT NAME: _____

EVENT TYPE: _____

EVENT DATE: _____/_____/_____ (to _____/_____/_____)

NODE ID:

|___|___|___|___|___|___|

SERVICES AND CHARGES CONTINUATION SHEET
FOR
SEPARATELY BILLING DOCTORS FOR REFERENCE YEAR 2005

B5a. I need to know what services were provided during (this visit/these visits). I would prefer the CPT-4 codes, if they are available.

[IF CPT-4 CODES ARE NOT USED, RECORD DESCRIPTIONS OF SERVICES AND PROCEDURES PROVIDED.]

B5b. ASK FOR EACH CPT-4 CODE OR DESCRIPTION: What was the **full established charge** for this service, before any adjustments or discounts?

[EXPLAIN IF NECESSARY: *The **full established charge** is the charge maintained in the physician's billing system for billing insurance carriers and Medicare or Medicaid. It is the "list price" for the service, before consideration of any discounts or adjustments resulting from contractual arrangements or agreements with insurance plans*.]

[IF NO CHARGE: *Some practices that don't charge for each individual service do associate dollar amounts with services for purposes of budgeting or cost analysis. This is sometimes called a **"charge equivalent."** Could you give me the charge equivalents for these procedures?*]

	CPT-4 (including modifier)	Full established charge at time of visit or charge equivalent
l.	_____	$_____.__
m.	_____	$_____.__
n.	_____	$_____.__
o.	_____	$_____.__
p.	_____	$_____.__
q.	_____	$_____.__
r.	_____	$_____.__
s.	_____	$_____.__
t.	_____	$_____.__
u.	_____	$_____.__
v.	_____	$_____.__
w.	_____	$_____.__
x.	_____	$_____.__
y.	_____	$_____.__
z.	_____	$_____.__
aa.	_____	$_____.__
bb.	_____	$_____.__
cc.	_____	$_____.__
dd.	_____	$_____.__
ee.	_____	$_____.__
ff.	_____	$_____.__
	TOTAL CHARGES	**$_____.__**

|__|__|
OFFICE USE ONLY

C2. [IF NOT VOLUNTEERED, ASK:] And what was the total? [IF NOT AVAILABLE, COMPUTE.]