

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	
10 BIRTHDATE		11 SEX F		12 DATE 0728XX		13 ADMISSION 01	
092952		14 TYPE 1		15 SRC 1		16 DHR 15	
17 STAT 01		18		19		20	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38	
39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
80		4					
43 REV.CD.		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	
2 260		IV THERAPY				4 1000 00	
3 300		LAB				1 235 00	
4 320		RADIOLOGY				1 250 00	
5 900		RESPIRATORY SERVICES				4 400 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.	
MEDICAID				Y		Y	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		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		67		68			
9		486 4928 30511		F G H			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
786.59		a		b		c	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		c OTHER PROCEDURE CODE	
87.44		0728XX					
75		76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI	
1234567890		WELLS MD		PHIL			
79 OTHER NPI							
80 REMARKS		81 CC a		82		83	
		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	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38 LYLES MELVIN 2001 MEADOW RD CAPITAL CITY NY 12345		39 CODE 80		40 CODE 3		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	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	
80 REMARKS		81 CC a		b		c	
d		e		f		g	

CASE C-3

1 CAPITAL CITY GENERAL HOSPITAL	2 C3		3a PAT CNTL # 646413		4 TYPE OF BILL 111			
1000 CHERRY ST			b MED REC # 84616489					
CAPITAL CITY NY 12345			5 FED. TAX. NO. 757575757		6 STATEMENT COVERS PERIOD FROM 0607XX THROUGH 0610XX			
5555551000								
8 PATIENT NAME a		9 PATIENT ADDRESS a 3009 RIVER RD						
b MENDEZ EMILIO			b CAPITAL CITY		c NY d 12345 e			
10 BIRTHDATE 093084		11 SEX M		12 DATE OF ADMISSION 0607XX		13 HR 17		
14 TYPE 1		15 SRC 7		16 DHR 11		17 STAT 01		
31 OCCURRENCE DATE A2		32 OCCURRENCE DATE 050371		33 OCCURRENCE DATE		34 OCCURRENCE DATE		
35 OCCURRENCE SPAN		36 OCCURRENCE SPAN		37 OCCURRENCE SPAN		38		
38 MENDEZ EMILIO 3009 RIVER RD CAPITAL CITY NY 12345			39 VALUE CODES AMOUNT a 80		40 VALUE CODES AMOUNT b 3		41 VALUE CODES AMOUNT c	
42 REV. CD. 1		43 DESCRIPTION ROOM BOARD SEMI		44 HCPCS/RATE/HIPPS CODE 400.00		45 SERV. DATE		
2		250 PHARMACY				46 SERV. UNITS 7		
3		260 IV THERAPY				47 TOTAL CHARGES 900 00		
4		300 LAB				48 NON-COVERED CHARGES 700 00		
5						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 0610XX		TOTALS 3200 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 1212121212		57 OTHER PRV. ID		
58 INSURED'S NAME MENDEZ EMILIO		59 18		60 INSURED'S UNIQUE ID YY2156349873		61 GROUP NAME		
62 INSURANCE GROUP NO. 252354		63 TREATMENT AUTHORIZATION CODES 5168431313		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME TOUGH GUYS GYM		
66 DX 03810		5265		F		G H		
69 ADMIT DX 5265		70 PATIENT REASON DX a		b		c		
74 PRINCIPAL PROCEDURE CODE DATE 9052		a OTHER PROCEDURE CODE DATE 0607XX		b OTHER PROCEDURE CODE DATE		c OTHER PROCEDURE CODE DATE		
75		76 ATTENDING NPI 9876543210		QUAL		73		
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST ALRIGHT MD FIRST ELBY		
80 REMARKS		81 CC a		b		77 OPERATING NPI QUAL		
		b		c		LAST FIRST		
		c		d		78 OTHER NPI QUAL		
		d				LAST FIRST		
						79 OTHER NPI QUAL		
						LAST FIRST		

CASE C-4

1 COUNTY COMMUNITY HOSPITAL 1600 CLOVER ST CAPITAL CITY NY 12345 5555551600		2 C4		3a PAT CNTRL # 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 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN 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	0 00
2	250	PHARMACY			5	400 00	0 00
3	260	IV THERAPY			2	950 00	0 00
4	270	MED SURG SUPPLIES			1	500 00	0 00
5	300	LAB			2	300 00	0 00
6	320	RADIOLOGY			1	650 00	0 00
7	360	OR SERVICES			1	1200 00	0 00
8	370	ANESTHESIA			1	600 00	0 00
23	001	PAGE 1 OF 1	CREATION DATE	1124XX	TOTALS	5400 00	0 00
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 57		OTHER PRV. ID	
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	
69 ADMIT DX 78903		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE 4709		DATE 1122XX		OTHER PROCEDURE CODE 8876		DATE 1122XX	
75 OTHER PROCEDURE CODE c		DATE d		OTHER PROCEDURE CODE e		DATE	
80 REMARKS		81 CC a		b		c	
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	

CASE C-5

1 TOWNSHIP MEMORIAL HOSPITAL 700 SHADY ST TOWNSHIP NY 12345 555550700		2 C5		3a PAT CNTL # 594313 b MED REC # RK654142		4 TYPE OF BILL 111	
8 PATIENT NAME a		9 PATIENT ADDRESS a 14 BERRY LN		5 FED. TAX. NO. 750750750		6 STATEMENT COVERS PERIOD FROM 1212XX THROUGH 1214XX	
b KEDAR RAMESH		b TOWNSHIP		c NY		d 12345	
10 BIRTHDATE 030767		11 SEX M		12 DATE 1212XX		13 HR 00	
14 TYPE 1		15 SRC 1		16 DHR 10		17 STAT 01	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38	
38 KEDAR RAMESH 14 BERRY LN 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	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 A HEALTH AMERICA		51 HEALTH PLAN ID B 87431		52 REL INFO C Y		53 ASG BEN D Y	
54 PRIOR PAYMENTS E 00:00		55 EST. AMOUNT DUE F		56 NPI G 67676767		57 OTHER PRV. ID H	
58 INSURED'S NAME A KEDAR RAMESH		59 B 18		60 INSURED'S UNIQUE ID C 65432678		61 GROUP NAME D	
62 INSURANCE GROUP NO. E 6649		63 TREATMENT AUTHORIZATION CODES A 54577888		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C WHOLESAL ELECTRONICS INC	
66 DX 9 41519		30000		4019		68 F G H	
69 ADMIT DX 786.05		70 PATIENT REASON DX a		b		71 PPS CODE c	
72 ECI a		b		c		73	
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	
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-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. 757575757		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 DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT	
a 80		b 4		c		d	
38 ZBEGAN ARTHUR 9832 GRASS 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	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
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	0001	PAGE 1 OF 1	CREATION DATE	0905XX	TOTALS	8625 00	0 00
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	
A MEDICARE		B 62541		Y	Y	C 00 00	
58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
A ZBEGAN ARTHUR		B 18	C 629417113A				
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A 5463664535							
66 DX		41181	41400	40200	V4581	F	G H
69 ADMIT DX		70 PATIENT REASON DX	71 PPS CODE		72 ECI	73	
A 4139		a	b	c			
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		75	
3612		0902XX		8944 0901XX		88.72 0901XX	
c OTHER PROCEDURE CODE		d OTHER PROCEDURE CODE		e OTHER PROCEDURE CODE		76 ATTENDING NPI	
8952		0901XX				0246802468	
80 REMARKS		81 CC		77 OPERATING NPI		QUAL	
a		b		LAST HART MD		FIRST IVA	
b		c		LAST		FIRST	
c		d		78 OTHER NPI		QUAL	
d				LAST		FIRST	
				79 OTHER NPI		QUAL	
				LAST		FIRST	

CASE C-7

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY STREET CAPITAL CITY NY 12345 555551000		2		3a PAT CNTL # 0063259 b MED REC # 000233168		4 TYPE OF BILL 0111	
8 PATIENT NAME a MANGINO RITA		9 PATIENT ADDRESS a 4 S. ORANGE WAY		c NY		d 12345	
10 BIRTHDATE 02081957		11 SEX F		12 DATE 0114XX		13	
31 OCCURRENCE DATE A2 110657		32 CODE		33 OCCURRENCE DATE		34 CODE	
38 MANGINO, RITA 4 S. ORANGE WAY, CAPITAL CITY NY 12345		39 CODE a 80		40 VALUE CODES AMOUNT 2		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
1 120	ROOM/BOARD/SEMI	450.00	0114XX	2	900 00	0 00	1
2 320	RADIOLOGY		0114XX	2	500 00	0 00	2
3 300	LAB		0114XX	1	105 00	0 00	3
4 260	IV THERAPY		0114XX	2	820 00	0 00	4
5 270	MED/SURG SUPPLIES		0114XX	5	400 00	0 00	5
6 250	PHARMACY		0114XX	1	375 00	0 00	6
7 900	RESPIRATORY SERVICES		0114XX	3	600 00	0 00	7
8			0114XX	3			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 0001	PAGE 1 OF 1	CREATION DATE	0116XX	TOTALS	3700 00	0 00	23
50 PAYER NAME A 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 A MANGINO, BRUCE		59 01	60 INSURED'S UNIQUE ID 4783900		61 GROUP NAME		62 INSURANCE GROUP NO. 493
63 TREATMENT AUTHORIZATION CODES A 5331648		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME CRITTER'S CAMPUS			
66 DX 9	5180	493.92		F	G	H	68
69 ADMIT DX 493.92	70 PATIENT REASON DX a	b	c	71 PPS CODE	72 ECI	a	b
74 PRINCIPAL PROCEDURE CODE 34.91	DATE 0114XX	87.44	0114XX	75	76 ATTENDING NPI 1234567890	QUAL	73
c OTHER PROCEDURE CODE DATE		d OTHER PROCEDURE CODE DATE	e OTHER PROCEDURE CODE DATE	76 LAST WELLS MD		FIRST PHIL	
77 OPERATING NPI		77 QUAL		78 OTHER NPI		QUAL	
78 LAST		78 FIRST		79 OTHER NPI		QUAL	
79 LAST		79 FIRST		80 REMARKS			

CASE C-8

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 123452222 5555551000		2 C8		3a PAT CNTL # 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 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 12121212		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		702		F		G H 68	
69 ADMIT DX 7802		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE DATE 0050 0814XX		a OTHER PROCEDURE CODE DATE 8944 0814XX		b OTHER PROCEDURE CODE DATE 8872 0814XX		75 76 ATTENDING NPI 0246802468 QUAL	
c OTHER PROCEDURE CODE DATE 8952 0814XX		d OTHER PROCEDURE CODE DATE		e OTHER PROCEDURE CODE DATE		LAST HART MD FIRST IVA	
80 REMARKS a		b		c		77 OPERATING NPI QUAL	
d		81CC a		b		LAST FIRST	
c		78 OTHER NPI QUAL		LAST FIRST		79 OTHER NPI QUAL	
d		LAST FIRST		LAST FIRST		LAST FIRST	

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	
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 MOORE VIRGINIA 934 SMITHFIELD ST CAPITAL CITY NY 12345		39 CODE 80		40 VALUE CODES AMOUNT 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	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
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23	001	PAGE 1 OF 1	CREATION DATE	0315XX	TOTALS	9625 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 12121212		57 OTHER PRV. ID			
58 INSURED'S NAME MOORE VIRGINIA		59 18	60 INSURED'S UNIQUE ID 629417113972		61 GROUP NAME		62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES 519843131		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
66 DX 82020		7310	71509	4019	F	G	H
69 ADMIT DX 82020		70 PATIENT REASON DX a b c		71 PPS CODE	72 ECI	a b c	73
74 PRINCIPAL PROCEDURE CODE 8151		75 OTHER PROCEDURE CODE 0312XX		76 ATTENDING NPI 1357613579		QUAL	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
80 REMARKS		81 CC a b c d		LAST TISS MD		FIRST ARTHUR	

CASE C-10

1 CAPITAL CITY GENERAL HOSPITAL		2 C10		3a PAT CNL # 015356		4 TYPE OF BILL 0111																			
1000 CHERRY ST				b MED REC # AK45329																					
CAPITAL CITY NY 123452222				5 FED. TAX. NO. 75757575		6 STATEMENT COVERS PERIOD FROM 0403XX THROUGH 0407XX																			
555551000																									
8 PATIENT NAME a			9 PATIENT ADDRESS a																						
b KIM ALBERT			b CAPITAL CITY																						
			c NY		d 12345		e																		
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 THROUGH		37 OCCURRENCE SPAN FROM THROUGH													
a										b															
38 KIM ALBERT 601 SUNFLOWER DR CAPITAL CITY NY 12345										39 VALUE CODES AMOUNT a 80 4		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	0210	CORONARY CARE			650.00				4	2600 00		0:00	1												
2	0250	PHARMACY							5	375 00		0:00	2												
3	0260	IV THERAPY							4	1000 00		0:00	3												
4	0270	MED SURG SUPPLIES							1	400 00		0:00	4												
5	0300	LAB							2	220 00		0:00	5												
6	0320	RADIOLOGY							2	550 00		0:00	6												
7	0730	EKG							1	150 00		0:00	7												
8	0900	RESPIRATORY SERVICES							1	400 00		0:00	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	0001	PAGE 1 OF 1			CREATION DATE			0407XX	TOTALS	5695 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	1212121212												
A MEDICARE			B 62541			Y	Y	00 00				57 OTHER PRV. ID	A												
C												C	C												
58 INSURED'S NAME			59	60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.															
A KIM ALBERT			18	629417113A									A												
B													B												
C													C												
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME																			
A 646819900														A											
B														B											
C														C											
66 DX	42001	4280							F	G	H	68													
9																									
69 ADMIT DX	7865	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73														
74 PRINCIPAL PROCEDURE CODE	3491	DATE	0405XX	OTHER PROCEDURE CODE	8744	DATE	0403XX	75	76 ATTENDING NPI	0246802468	QUAL														
									LAST	HART MD	FIRST	IVA													
c OTHER PROCEDURE CODE		DATE		d OTHER PROCEDURE CODE		DATE		e OTHER PROCEDURE CODE		DATE															
77 OPERATING NPI																									
78 OTHER NPI																									
79 OTHER NPI																									
80 REMARKS				81 CC	a																				
					b																				
					c																				
					d																				

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	
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 MARSELLE OLIVIA 4142 VALLEY RD CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 CODE		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	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
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	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		a		b	
75		c		d		e	
76 ATTENDING NPI 1471471471		QUAL		LAST LOTTS MD		FIRST KAREN	
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-12

1 CAPITAL CITY GENERAL HOSPITAL 1000 CHERRY ST CAPITAL CITY NY 12345 5555551000		2 C12		3a PAT CNTRL # 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		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH	
a A2		073059					
b							
38 RODRIGUEZ ANTONIO 32 PLANK CIR CAPITAL CITY NY 12345		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a		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	
1 260		IV THERAPY		0518XX		1 400 00	
2 270		MED SURG SUPPLIES		0518XX		1 500 00	
3 500		AMBUL SURG		45384		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		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A BLUE CROSS BLUE SHIELD		87590		Y Y		54 PRIOR PAYMENTS 00 00	
B						55 EST. AMOUNT DUE	
C						56 NPI 121212121	
58 INSURED'S NAME		59		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A RODRIGUEZ CASSANDRA		01		YY294004954		62 INSURANCE GROUP NO. 727524	
B							
C							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A				RICHIE RICH BANK OF USA			
B							
C							
66 DX 2303						68	
9							
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		E9304	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE CODE		b OTHER PROCEDURE CODE		75	
76 ATTENDING NPI 0123456789		QUAL		LAST MENDES 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 # 04698 b MED REC # RP1297		4 TYPE OF BILL 131	
5 FED. TAX. NO. 707070707		6 STATEMENT COVERS PERIOD FROM 1125XX THROUGH 1125XX		7			
8 PATIENT NAME a PAUL RANDALL			9 PATIENT ADDRESS a 231 BOSTON AVE APT 5				
b CAPITAL CITY			c NY		d 12345		
10 BIRTHDATE 120959		11 SEX M		12 DATE 1125XX		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	
38 PAUL RANDALL 231 BOSTON AVE APT 5 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		1125XX	1	90 00	0 00
2	260	IV THERAPY		1125XX	1	575 00	0 00
3	320	RADIOLOGY	74170	1125XX	1	850 00	0 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	1125XX	TOTALS	1515 00	0 00
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 676767676		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 78930		F		G		H	
67		68		69		70	
71		72		73		74	
75		76		77		78	
79		80		81		82	
83		84		85		86	
87		88		89		90	
91		92		93		94	
95		96		97		98	
99		100		101		102	

CASE C-15

1 COUNTY COMMUNITY HOSPITAL		2 C15		3a PAT CNTL # 665090		4 TYPE OF BILL 131	
1600 CLOVER ST				b MED REC # PV7539			
CAPITAL CITY NY 12345				5 FED. TAX. NO. 707070707		6 STATEMENT COVERS PERIOD FROM 0619XX THROUGH 0619XX	
555551600							
8 PATIENT NAME a			9 PATIENT ADDRESS a				
b VLAH PATRICIA			b TOWNSHIP				
c NY			d 12345				
10 BIRTHDATE 021100		11 SEX F		12 DATE 0619XX		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 0619XX		33 OCCURRENCE DATE	
34 CODE		35 OCCURRENCE DATE		36 CODE		37 OCCURRENCE DATE	
38 VLAH SUZANNE		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
988 MILL RUN RD		a		b		c	
TOWNSHIP		b		c		d	
NY		c		d		e	
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		0619XX	1	150 00	0 00
2	260	IV THERAPY		0619XX	1	750 00	0 00
3	270	MED SURG SUPPLIES		0619XX	1	400 00	0 00
4	370	ANESTHESIA		0619XX	1	700 00	0 00
5	500	AMBUL SURG	42820	0619XX	1	1500 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	0619XX	TOTALS	3500 00	0 00
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 VLAH SUZANNE		59 19		60 INSURED'S UNIQUE ID 6561946		61 GROUP NAME	
62 INSURANCE GROUP NO. 649104							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME CUTS N CURLS SALON			
66 DX 9		67		68			
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

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	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
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
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	0619XX	TOTALS	725 00	0 00
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			
HEALTH AMERICA		62400		Y	Y	00 00	
58 INSURED'S NAME		59	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.
CHUNG MICHAEL		43	4684646				5215
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME	
						CUTS N CURLS SALON	
66 DX		67		68		69	
4878				F		G H	
9							
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
73		74		75		76	
PRINCIPAL PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		76 ATTENDING NPI 1471471471	
DATE		DATE		DATE		QUAL	
						LAST LOTTS MD FIRST KAREN	
77 OPERATING NPI		78 OTHER NPI		79 OTHER NPI		QUAL	
DATE		DATE		DATE		QUAL	
						LAST FIRST	
80 REMARKS		81 CC		82		83	
		a		b		c	
		b		c		d	
		c		d			
		d					

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					
b 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	
30		31		32		33	
34		35		36		37	
38 LOMBARDO KEITH 174 JEFFERSON ST TOWNSHIP 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	76770	0106XX	1	300 00	0 00
2	0972	RADIOLOGIST		0106XX	1	125 00	0 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	54 PRIOR PAYMENTS	
A MEDICARE		15877		Y	Y	00:00	
58 INSURED'S NAME		59		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A LOMBARDO KEITH		18		649331304A			
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A		B		C			
66 DX		67		68		69	
9		F		G		H	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		c OTHER PROCEDURE DATE	
76 ATTENDING NPI 1234567890		QUAL		73			
LAST WELLS MD		FIRST PHIL					
77 OPERATING NPI		QUAL					
LAST		FIRST					
80 REMARKS		81 CC a		78 OTHER NPI		QUAL	
		b		LAST		FIRST	
		c		79 OTHER NPI		QUAL	
		d		LAST		FIRST	

CASE C-18

1 TOWNSHIP MEMORIAL HOSPITAL		2 C18		3a PAT CNTL # 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	
38 CLARK TYRONE		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
55 LOCKWOOD DR							
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				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 A MEDICAID		51 HEALTH PLAN ID 43062		52 REL INFO Y		53 ASG BEN. Y	
54 PRIOR PAYMENTS 00 00		55 EST. AMOUNT DUE		56 NPI 3434343434		57 OTHER PRV. ID	
58 INSURED'S NAME A CLARK TYRONE		59 18		60 INSURED'S UNIQUE ID 498481614		61 GROUP NAME	
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES A		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C			
66 DX 9		67 F		68 G		H	
69 ADMIT DX		70 PATIENT REASON DX a		b		c	
74 PRINCIPAL PROCEDURE CODE		a OTHER PROCEDURE DATE		b OTHER PROCEDURE DATE		c OTHER PROCEDURE DATE	
75		76 ATTENDING NPI 1471471471		QUAL		73	
77 OPERATING NPI		QUAL		LAST LOTTS MD		FIRST KAREN	
78 OTHER NPI		QUAL		LAST		FIRST	
79 OTHER NPI		QUAL		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 5328651498A		61 GROUP NAME C		62 INSURANCE GROUP NO. D	
63 TREATMENT AUTHORIZATION CODES A		64 DOCUMENT CONTROL NUMBER B		65 EMPLOYER NAME C			
66 DX 9 81344		F		G		H	
69 ADMIT DX		70 PATIENT REASON DX a 7295		b		c	
71 PPS CODE		72 ECI E8809		a		b	
73		74 PRINCIPAL PROCEDURE CODE		b OTHER PROCEDURE DATE		75	
76 ATTENDING NPI 1471471471		QUAL		LAST LOTTS MD		FIRST KAREN	
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-20

1 TOWNSHIP MEMORIAL HOSPITAL		2 C20		3a PAT CNTRL # 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 ADMISSION 14 TYPE 15 SRC 1	
16 DHR 01		17 STAT 01		18 19 20 21		CONDITION CODES 22 23 24 25 26 27 28 29 ACDT 30 STATE	
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 388 ATLANTIC AVE TOWNSHIP 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	0250	PHARMACY		0720XX	1	175 00	0 00
2	0260	IV THERAPY		0720XX	1	825 00	0 00
3	0270	MED SURG SUPPLIES		0720XX	1	450 00	0 00
4	0300	LAB		0720XX	1	375 00	0 00
5	0310	LAB PATH		0720XX	1	300 00	0 00
6	0370	ANESTHESIA		0720XX	1	750 00	0 00
7	0500	AMBUL SURG	38510	0720XX	1	1700 00	0 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	0 00
50 PAYER NAME A MEDICARE		51 HEALTH PLAN ID B 15877		52 REL INFO C Y	53 ASG BEN. D Y	54 PRIOR PAYMENTS E 00 00	
55 EST. AMOUNT DUE F		56 NPI G 34343434		57 OTHER PRV. ID H			
58 INSURED'S NAME A MASTERS JENNA		59 B 18		60 INSURED'S UNIQUE ID C 853614253A		61 GROUP NAME D	
62 INSURANCE GROUP NO. E		63 TREATMENT AUTHORIZATION CODES F		64 DOCUMENT CONTROL NUMBER G		65 EMPLOYER NAME H	
66 DX I 9		67 F 7856		68 G		69 H	
69 ADMIT DX J		70 PATIENT REASON DX K a		b		71 PPS CODE L c	
72 ECI M a		73 b		74 PRINCIPAL PROCEDURE CODE N a		75 OTHER PROCEDURE DATE b	
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					

