

# BAY STATE EYE ASSOCIATES

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## Date of Service

## Copay Received \$

Patient Name:

Mr / Ms \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

Street Address: \_\_\_\_\_ Apt / Unit # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Numbers:

Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Marital Status:  Married  Divorced  Separated  
 Single  Widowed

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ ID # \_\_\_\_\_

SHOULD BE EXACTLY AS IT APPEARS ON CARD - INCLUDE ANY PREFIX OR SUFFIX

Policy Holder :

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

**I understand that my insurance, based on information I have provided, will be billed for services rendered at this office as a courtesy, and if for any reason the services are not covered by my insurance I understand that I am responsible for payment in full.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### OFFICE USE ONLY

DIAGNOSIS CODE:			<input type="checkbox"/> WAIVER SIGNED (-GA Modifier)		
<b>New Patient Visits</b>			<b>Established Patient Visits</b>		
<input checked="" type="checkbox"/>	<b>Code</b>	<b>Description</b>	<input checked="" type="checkbox"/>	<b>Code</b>	<b>Description</b>
<input type="checkbox"/>	92002	Intermediate	<input type="checkbox"/>	92012	Intermediate
<input type="checkbox"/>	92004	Comprehensive	<input type="checkbox"/>	92014	Comprehensive
<input type="checkbox"/>	99202	Focused Complexity, E & M	<input type="checkbox"/>	99212	Focused Complexity, E & M
<input type="checkbox"/>	99203	Low Complexity, E & M	<input type="checkbox"/>	99213	Low Complexity, E & M
<input type="checkbox"/>	99204	Moderate Complexity, E & M	<input type="checkbox"/>	99214	Moderate Complexity, E & M
<b>Supplies</b>			<b>Mass Health Supplies (includes frame &amp; pair of lenses)</b>		
<input type="checkbox"/>	V2103	Frame w/ Single Vision Lenses	<input type="checkbox"/>	92340	Fitting of spectacles, monofocal
<input type="checkbox"/>	V2203	Frame w/ Bifocal Lenses	<input type="checkbox"/>	92341	Fitting of spectacles, bifocal
<input type="checkbox"/>	V2219	Progressive Lenses	<input type="checkbox"/>	92342	Fitting of spectacles, multifocal (other than bi)
<input type="checkbox"/>	V2319	Frame w/ Trifocal Lenses	<input type="checkbox"/>	92340	2nd Pair of Single Vision Lenses
<b>Procedures</b>					
<input type="checkbox"/>	92100	Tonometry	<input type="checkbox"/>	65222	Removal FB, corneal, w/ slit lamp
<input type="checkbox"/>	92225	Extended Ophthalmoscopy	<input type="checkbox"/>	67820	Correction of trichiasis by forceps
<input type="checkbox"/>	92226	Ophthalmoscopy, subsequent	<input type="checkbox"/>	92015	Refraction - <b>NO MEDICARE</b>
<input type="checkbox"/>	92285	External Ocular Photography	<input type="checkbox"/>	68761	Closure of lacrimal punctum, _____ plugs used
<input type="checkbox"/>			<input type="checkbox"/>	92082	Visual field exam, intermediate
<input type="checkbox"/>	<b>-25</b>	<b>Modifier -25 (check if applies)</b>	<input type="checkbox"/>	92083	Visual field exam, extended