Reference Example 1

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.BM-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 01
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE S
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.P.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. THERAP. REL. TO DIAG.	30. THERAP. REL. TO NAM. FL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV
A	120107		Ear impression	V5275			2	$ 70 00	$	
B	120107		Binaural dispensing	V5160			1	2500 00		
C	120107		Binaural digital ITE	V5260			1	653 00		
D	120107		Batteries, 3 packs/4	V5266			12	21 00		
E	120107		Options/accessories	V5267			1	75 60		
F										
G										
H										
I										
J										

35. REMARKS:

V5267 invoice $54.00, plus 40% markup ($21.60) = $75.60
V5260 invoice $317.00+$317.00 = $634.00*, plus shipping ($19.00) = $653.00

* use the AAC of the base model to determine if P.A. is needed based on cost. If total AAC for both units > $1,000.00, P.A. is required

36. TOTAL USUAL FEE $
37. TOTAL OTHER PAID AMOUNT $

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

38. AUTHORIZED SIGNATURE
39. BILLING DATE

CLM-9 (Rev. 6/...)

PRINTED ON RECYCLED PAPER

Reference Example 1

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Number

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			707.00

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

10 Constitution Ave.
Piscataway, NJ 08855, USA
(800) 766-4500 Local Call: (732) 562-6600

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Order No.	Order Date	Terms	Shipment Method	Invoice Date
		Net 30 Days	DHL OVERNIGHT/NEXT DAY	

Line No. / Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	W/R/MO	List Price	Extension	Discount Price	Invoice Amount
1 LS-C	ITC INTUIS	1	1	12	492.00	492.00	317.00	317.00
	TELECOIL	1	1		60.00	60.00	54.00	54.00

Slope	Gain	Power	HFL	Side	Warranty	Serial No.
03	50	118	WIDE	LEFT		

Case
Beige - Shell Color
Shell SAV
Long - Canal Length
Wire Spring
Feedback Seal
Left Tonepiece 4
3/12 Ref Faceplate(LS-BISSATC)

INTUIS
Left - Side
1 Control
Wide - HFL
3 db per Octave - Slope
50 db - Gain (Preset)
Beige - Faceplate Color
118 db - Power (Preset)

Programmable Connector
No Standard Control 2
Removed Sling
Wind Screen
VOLUME CONTROL
PUSHBUTTON SWITCH
BAROMETRIC UNSUSPENDED
12 MONTH WARRANTY

Slope	Gain	Power	HFL	Side	Warranty	Serial No.
03	50	118	WIDE	RIGHT		

Case
Beige - Shell Color
Shell SAV
Long - Canal Length
Wire Spring
Feedback Seal
Right Tonepiece 4
3/12 Ref Faceplate(LS-BISSATC)

INTUIS
Right - Side
1 Control
Wide - HFL
3 db per Octave - Slope
50 db - Gain (Preset)
Beige - Faceplate Color
118 db - Power (Preset)

Programmable Connector
No Standard Control 2
Removed Sling
Wind Screen
VOLUME CONTROL
PUSHBUTTON SWITCH
BAROMETRIC UNSUSPENDED
12 MONTH WARRANTY

2 LS-C	ITC INTUIS	1	1	12	492.00	492.00	317.00	317.00

EVERY EFFORT HAS BEEN MADE TO SATISFY YOUR ORDER. DUE TO PACKLIMITATIONS A SMALLER RECEIVER HAD TO BE USED.

Subtotal	688.00
Tax Amount	0.00
Shipping	19.00
TOTAL	707.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

Reference Example 2

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.8M-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 02
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE &
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. THEAT. REL. TO DISC.	30. THEAT. REL. TO PAR. DI.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. STAT.
A	120107		Major repair	V5014			2	$ 394 45	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

36. TOTAL USUAL FEE $
37. TOTAL OTHER PAID AMOUNT $

Calculate Charges:

invoice cost of 2 repairs $226.00 + shipping $19.00 = $245.00, plus 40% markup ($98.00) = $343.00

Then, add 15% out-of-office increase for place of service 02 ($51.45) = $394.45

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

38. AUTHORIZED SIGNATURE
39. BILLING DATE

40. ADJUSTMENT
RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

PRINTED ON RECYCLED PAPER

Reference Example 2

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Number:

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
10			

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

10 Constitution Ave.
Piscataway, NJ 08855, USA
(800) 766-4500 Local Call: (732) 562-6600

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.
[illegible]			

Terms	Shipment Method	Invoice Date
Net 30 Days	DHL OVERNIGHT/NEXT DAY	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 SINNN05A	PROG ANALOG ITE OUT OF WARR	1	1	6	113.00	113.00	113.00	113.00

Item No.	Hearing Aid Description	War Exp Date	Serial No.
LS-I	ITE		

Complaint	Action Description
Dead	Receiver Replaced - Clogged
Weak/Not up to Spec.	Microphone Replaced
Wax Build Up	Receiver Replaced - Clogged
Tubing (mic./rec.)	Receiver Pocket/Tubing Replace

2 SINNN05A	PROG ANALOG ITE OUT OF WARR	1	1	6	113.00	113.00	113.00	113.00

Item No.	Hearing Aid Description	War Exp Date	Serial No.
LS-I	ITE		

Complaint	Action Description
Dead	Receiver Replaced - Clogged
Wax Build Up	Receiver Replaced - Clogged
Wax Build Up	Microphone Replaced
Tubing (mic./rec.)	Receiver Pocket/Tubing Replace

PROGRAMMED TO RECEIVED SETTINGS.

Subtotal	226.00
Tax Amount	0.00
Shipping	19.00
TOTAL	245.00

[illegible] as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each [illegible] including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid [illegible] Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

DocOrm[illegible] Job[illegible]

Reference Example 3

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1 BM-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY:
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY:
2. PAY TO PROVIDER NO.:
3. BILLING AGENT NO.:
4. PRIOR AUTHORIZATION NO.: If applicable

5. SERVICING PROVIDER'S NAME:
6. SERVICING PROVIDER NO.:
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable

9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.:
14. PATIENT ACCOUNT NO.: internal patient acct #

15. PLACE OF SERVICE: 01
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE &
C. DATE OF ACCIDENT:
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.:
19. PATIENT STATUS:
20. DISCHARGE DATE:

21. DIAGNOSIS CODE:
22. DIAGNOSIS NAME:
23. DIAGNOSIS CODE:
24. DIAGNOSIS NAME:

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT. REL. TO DIAG.	30. TREAT. REL. TO PER. C.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Major repair	V5014			1	$ 263 20	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

36. TOTAL USUAL FEE: $
37. TOTAL OTHER PAID AMOUNT: $

Calculate Charges:
invoice cost of repair $171.00 + shipping $17.00 = $188.00, plus 40% markup ($75.20) = $263.20

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

38. AUTHORIZED SIGNATURE
39. BILLING DATE

PRINTED ON RECYCLED PAPER

Reference Example 3

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Numbe

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			0

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

14351 Firestone Blvd.
La Mirada, CA 90638, USA
Tel: (714) 670-8216 (800) 998 -9787

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Order No.	Order Date	Terms	Shipment Method	Invoice Date
		Days	DHL OVERNIGHT/NEXT DAY	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 SIXXXXDSA	PROG ANALOG ITE OUT OF WARR	1	1	6	113.00	113.00	108.00	108.00
	REMAKE/RECASE- NO MODEL CHANGE	1	1		63.00	63.00	63.00	63.00

Item No.	Hearing Aid Description	War Exp Date	Serial No.
LS-I	ITE		

Complaint	Action Description
Additional Work Done	Programmed To User Settings (B
Shell Repair	Shell Remade
Shell Repair	Faceplate Replaced-Plastic Onl

Subtotal	171.00
Tax Amount	0.00
Shipping	17.00
TOTAL	188.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

Reference Example 4

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.BM-11/00 G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 01
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL TO DIAG	30. TREAT REL TO DIAG	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Pocket talker	V5274			1	$ 158 14	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

Calculate Charges:
invoice cost $106.04, plus shipping ($6.92) = $112.96, plus 40% markup ($45.18) = $158.14

36. TOTAL USUAL FEE $
37. TOTAL OTHER PAID AMOUNT $

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

38. AUTHORIZED SIGNATURE
39. BILLING DATE

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

PRINTED ON RECYCLED PAPER

Reference Example 4

AHAA

AMERICAN HEARING AID ASSOCIATES

Helping America Hear Well Again.

***** Invoice *****

Invoice Number:

Manufacturers Number:

Invoice Date:

Due Date:

Sold To:

Ship To:

Customer #:

Patient:

Manufacturer: Hal-Hen Company Inc.

Item Number	Description	Quantity	Unit	Price	Ext. Price
	Pocketalker Pro w/ Headphones	1	Each	$ 106.04	$ 106.04
Shipping	Shipping	1	Each	$ 6.92	$ 6.92

Total:	$ 112.96
Tax:	$ 0.00
Total:	$ 112.96

P.O. Box 4000, West Chester, PA 19380 • Toll Free: 800-984.3272 • Local Phone: 610-455-3010 • Fax: 610-455-3019 • E-mail: info@ahaanet.com

Reference Example 5

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.6M-11/00-C100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY:
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY:
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable

9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #

15. PLACE OF SERVICE: 06
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE

21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO TEETH	30. TREAT REL. TO FACE	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Major repair	V5014			1	$ 302 68	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

36. TOTAL USUAL FEE: $
37. TOTAL OTHER PAID AMOUNT: $

Calculate Charges:

invoice cost of repair = $171.00, + shipping ($17.00) = $188.00, plus 40% markup ($75.20) = $263.20

Then, add 15% out-of-office increase for place of service 06 ($39.48) = $302.68

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.

Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY

38. AUTHORIZED SIGNATURE
39. BILLING DATE

A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

PRINTED ON RECYCLED PAPER

Reference Example 5

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Number:

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			188.00

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

14351 Firestone Blvd.
La Mirada, CA 90638, USA
Tel: (714) 670-8216 (800) 998 -9787

Page 1 of 1

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Order No.	Order Date	Terms	Shipment Method	Invoice Date
		Net 30 Days	DHL-OVERNIGHT/NEXT DAY	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 STOCKTEA	PROG ANALOG ITE OUT OF WARR	1	1	6	113.00	113.00	108.00	108.00
	REMAKE/RECASE- NO MODEL CHANGE	1	1		63.00	63.00	63.00	63.00

Item No.	Hearing Aid Description	War Exp Date	Serial No.
LS-I	TE		

Complaint	Action Description
Additional Work Done	Programmed To User Settings (B
Shell Repair	Shell Remade
Shell Repair	Faceplate Replaced-Plastic Onl

Subtotal	171.00
Tax Amount	0.00
Shipping	17.00
TOTAL	188.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

Reference Example 6

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.BM-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY:
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY:
2. PAY TO PROVIDER NO.:
3. BILLING AGENT NO.:
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME:
6. SERVICING PROVIDER NO.:
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.:
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 01
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT?: X NO YES
B. IF YES, TYPE:
C. DATE OF ACCIDENT:
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING?: X NO YES
18. L.O.F.:
19. PATIENT STATUS:
20. DISCHARGE DATE:
21. DIAGNOSIS CODE:
22. DIAGNOSIS NAME:
23. DIAGNOSIS CODE:
24. DIAGNOSIS NAME:

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT. REL. TO DIAG.	30. TREAT. REL. TO PRI.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Binaural ITE	V5130			1	$ 228 99	$	
B	120107		Binaural dispensing	V5160			1	3500 00		
C	120107		Accessories	V5267			2	784 00		
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

V5267 invoice $280.00+$280.00 = $560.00, plus 40% markup $224.00 = $784.00

V5130 invoice $157.00 + $157.00 = $314.00*, -$100 credit on invoice = $214.00, + shipping $14.99 = $228.99

* use the AAC of the base model to determine if P.A. is needed based on cost. If total AAC for both units > $1,000.00, P.A. is required

36. TOTAL USUAL FEE: $
37. TOTAL OTHER PAID AMOUNT: $

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.

Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

38. AUTHORIZED SIGNATURE
39. BILLING DATE

PRINTED ON RECYCLED PAPER

Reference Example 6

New Hearing Aid Invoice

DATE SHIPPED: [redacted]

BILL TO: [redacted]

Invoice Number: [redacted]

SHIPPED FROM:
STARKEY - MASSACHUSETTS
23 Crosby Drive
Bedford, MA 01730

DATE DUE: [redacted]

For questions about this order, Call
1-(800) 228-0080
Local: (781) 275-4680

For: [redacted]

LEFT	STARKEY	CE	N
[redacted]		157.00	
MATRIX: 113/30/05-VV			
WARRANTY: 12 mo. EXPIRES: [redacted]			
OPTIONS			
AXENT III		280.00	
CONFORMER COAT			N/C
WAXCEPTOR			N/C
SINGLE MEMORY CONFIG			N/C
SERIES 12 FACEPLATE			N/C
13 BATT			N/C
DOUBLE V.C. CAP			N/C
5 MM VOLUME CONTROL			N/C
Sub Total:		437.00	

RIGHT	STARKEY	CE	N
[redacted]		157.00	
MATRIX: 113/30/05-VV			
WARRANTY: 12 mo. EXPIRES: [redacted]			
OPTIONS			
AXENT III		280.00	
ROUND TRIP INS/SHP/HNDLG		14.99	
CONFORMER COAT			N/C
WAXCEPTOR			N/C
SINGLE MEMORY CONFIG			N/C
SERIES 12 FACEPLATE			N/C
13 BATT			N/C
DOUBLE V.C. CAP			N/C
5MM VOLUME CONTROL			N/C
Sub Total:		451.99	
		.00	
		.00	

1 INVOICES TO SUB OFFICE

[redacted]

TOTAL: 888.99

Amount Paid:

P.O. Number:

Check Number:

Thank you for the opportunity to serve you!

CREDITS - LEFT	CREDITS - RIGHT
- 50.00	[redacted] - 50.00
	[redacted]
	[redacted]
Sub Total: .00	Sub Total: .00
	.00
	TOTAL CREDITS: 100.00

INVOICE TOTAL: 88.99

N116675
© 71543-007 10/06 FORM1543-01-EE-XX

Reference Example 7

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.8M-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY:
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY:
2. PAY TO PROVIDER NO.:
3. BILLING AGENT NO.:
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME:
6. SERVICING PROVIDER NO.:
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.:
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 06
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE:
C. DATE OF ACCIDENT:
17. IS MEMBER BEING TREATED AS A RESULT OF DRUG SCREENING? X NO YES
18. L.O.F.:
19. PATIENT STATUS:
20. DISCHARGE DATE:
21. DIAGNOSIS CODE:
22. DIAGNOSIS NAME:
23. DIAGNOSIS CODE:
24. DIAGNOSIS NAME:

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO SUB. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. SERVIC. SERV.
A	120107		Major repair	V5014			2	$ 399 28	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

36. TOTAL USUAL FEE: $
37. TOTAL OTHER PAID AMOUNT: $

Calculate Charges:

invoice cost $108.00+$108.00 = $216.00, + shipping ($16.00+$16.00) = $248.00, plus 40% markup ($99.20) = $347.20

Then, add 15% out-of-office increase for place of service 06 ($52.08) = $399.28

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.

Signed under the pains and penalties of perjury.

38. AUTHORIZED SIGNATURE
39. BILLING DATE

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

CLM 9 Rev. 03/97

PRINTED ON RECYCLED PAPER

Reference Example 7

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Number

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			124.00

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

Page 1 of 1

10 Constitution Ave.
Piscataway, NJ 08855, USA
(800) 766-4500 Local Call: (732) 562-6600

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Order No.	Order Date	Terms	Shipment Method	Invoice Date
		Net 30 Days	DHL OVERNIGHT/NEXT	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 STNNN05A	PROG ANALOG ITE OUT OF WARR	1	1	6	108.00	108.00	108.00	108.00

Item No.	Hearing Aid Description	War Exp Date	Serial No.
LS-I	ITE		

Complaint	Action Description
Weak/Not up to Spec.	Microphone Replaced - Clogged
Distorted/Noisy/Static	Receiver Replaced - Clogged
Battery Door	Battery Door Replaced

PROGRAMMED TO RECEIVED SETTINGS.

Subtotal	108.00
Tax Amount	0.00
Shipping	16.00
TOTAL	124.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

DocDmrP:9.1.0.56/R: Job:24976.3501373051

Reference Example 7

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Custom
Crafted for:
Serial Number:

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			124.00

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

10 Constitution Ave.
Piscataway, NJ 08855, USA
(800) 766-4500 Local Call: (732) 562-6600

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Order No.	Order Date	Terms	Shipment Method	Invoice Date
		Net 30 Days	DHL OVERNIGHT	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 SINNNO5A	PROG ANALOG ITE OUT OF WARR	1	1	6	108.00	108.00	108.00	108.00

Item No.	Hearing Aid Description	Warr Exp Date	Serial No.
LS-I	ITE		

Complaint Code	Action Description
Weak/Not up to Spec. Distorted/Noisy/Static Battery Door	Microphone Replaced - Clogged Receiver Replaced - Clogged Battery Door Replaced

PROGRAMMED TO RECEIVED SETTINGS.

Subtotal	108.00
Tax Amount	0.00
Shipping	16.00
TOTAL	124.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.

Reference Example 8

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1.8M-11/00-G100060

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.	1A. BILLING PROVIDER NPI	1B. BILLING PROVIDER TAXONOMY
Provider Name Address Phone #	Billing NPI	
	1C. RENDERING PROVIDER NPI	1D. RENDERING PROVIDER TAXONOMY
	Servicing NPI	
	2. PAY TO PROVIDER NO. / 3. BILLING AGENT NO.	4. PRIOR AUTHORIZATION NO.
		if applicable

5. SERVICING PROVIDER'S NAME	6. SERVICING PROVIDER NO.	7. REFERRING PROVIDER'S NAME	8. REFERRING PROVIDER NO.
		MassHealth PCC ONLY	PCC referral, if applicable

9. MEMBER'S NAME	10. MEMBER ID NO.	11. DATE OF BIRTH	12. SEX	13. OTHER INSUR.	14. PATIENT ACCOUNT NO.
member name	member RID	DOB	M/F		internal patient acct #

15. PLACE OF SERVICE	16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT?	B. IF YES, TYPE	C. DATE OF ACCIDENT	17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING?	18. L.O.F.	19. PATIENT STATUS	20. DISCHARGE DATE
01	X NO YES			X NO YES			

21. DIAGNOSIS CODE	22. DIAGNOSIS NAME	23. DIAGNOSIS CODE	24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Binaural dispensing	V5160			1	$ 2000 00	$	
B	120107		Binaural BTE	V5140			1	1000 00		
C	120107		Earmolds	V5264			2	125 64		
D	120107		Batteries, 3 packs/8	V5266			24	45 00		
E										
F										
G										
H										
I										
J										

35. REMARKS:

$ 36. TOTAL USUAL FEE

$ 37. TOTAL OTHER PAID AMOUNT

V5140 invoice $1,000.00*

V5264 invoice $69.00, plus shipping ($29.60) = $98.60, plus dispensing fee ($13.52 per earmold) = $125.64

* use the AAC of the base model to determine if P.A. is needed based on cost. If total AAC for both units > $1,000.00, P.A. is required

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.

Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL 41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY

A. ATTACHMENT CODE B. CODE C. CODE D. CODE

38. AUTHORIZED SIGNATURE 39. BILLING DATE

CLM-3 (Rev. 03/07)

PRINTED ON RECYCLED PAPER

Reference Example 8

oticon
PEOPLE FIRST

Invoice

Packed with Shipment
Billto No.. . . . . .
Customer No. . . . . .
External Customer No.. . .
Ordering Clinic. . . . . .
Contact . . . . . .
P.O. Number. . . . . .
Customer's Reference. . .
Medicaid ID . . . . . .
Contract No.. . . . . .
Order Date. . . . . .
Order No. . . . . .
Invoice Date . . . . . .
Payment Terms . . . . . .
Due Date. . . . . .

Page 1

	Qty.	Unit Price	Gross Amount	Discount %	Discount Amount	Amount
Sumo DM Color: Dark Brown Battery: 675 Serial No. Serial No.	2 EACH	500.00	1,000.00			1,000.00
	2 2 Year					0.00

Total $	1,000.00
Tax Amount	0.00
Total $ Incl. Sales Tax	1,000.00

Past due balances are subject to a charge of 1.5% per month or 18% annually.

www.oticonusa.com

Please Remit Payment To:

Oticon Inc.
P.O. Box 8500-52843
Philadelphia, PA 19178-2843

1.800.526.3921 Main
1.732.560.1220
1.732.560.0760 Fax

Reference Example 8

Emtech Laboratories, Inc.
P.O. Box 12900 • Roanoke, VA 24022-2900

INVOICE

Phone: (800) 336-5719

Ship To Address:
Ship To:

Client Name

Ear		B	
Style	2	SHELL	.00
Material	2	EMPLEX II	69.00
SHIPPING			29.60

Bill To Address:

BROWN NO-JC MED Total: 98.60

Terms: all amounts due thirty days following invoice date. A 2% service charge, annual percentage rate 24%, applies to all balances over 30 days.

REFER TO PRICE SHEET FOR OTHER PRICING, TERMS AND CONDITIONS.

Reference Example 9

9

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 01
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29.	30.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV
A	120107		Monaural dispensing	V5241RT			1	$ 1500 00	$	
B	120107		Monaural ITE	V5050RT			1	513 72		
C	120107		Ear impression	V5275			1	35 00		
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

36. TOTAL USUAL FEE: $
37. TOTAL OTHER PAID AMOUNT: $

Calculate Charges:

V5050RT invoice cost $498.73*, plus shipping ($14.99) = $513.72

* use the AAC of the base model to determine if P.A. is needed based on cost. If AAC > $500.00, P.A. is required

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

40. ADJUSTMENT RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

38. AUTHORIZED SIGNATURE
39. BILLING DATE

PRINTED ON RECYCLED PAPER

Reference Example 9

New Hearing Aid Invoice

DATE SHIPPED
Date Shipped

BILL TO:

Invoice Number

SHIPPED FROM:
STARKEY LABORATORIES, INC.
P.O. Box 9457
Minneapolis, MN 55440

For questions about this order, Call
1-(800) 328-8602
Local: (952) 941-6401

For:

RIGHT	STARKEY	CE LV
S/N:		498.73
MATRIX: 113/30/05-VV		
WARRANTY: 1		
OPTIONS:		
Low Profile		N/C
ROUND TRIP INS/SHP/HNDLG		14.99
CANAL VOLUME CONTROL		N/C
ENDEAVOUR IV		N/C
WAXCEPTOR		N/C
SINGLE MEMORY CONFIG		N/C
SERIES 12 FACEPLATE		N/C
312 BATTERY		N/C

Sub Total: 513.72
.00
.00

1 INVOICES TO MAIN OFFICE

TOTAL: 513.72

Amount Paid

P.O. Number

Check Number

Thank you for the opportunity to serve you!

CREDITS - RIGHT

Sub Total: .00
.00
TOTAL CREDITS: .00

INVOICE TOTAL: 513.72

N107179
© 71543-007 10/06 FORM1543-01-EE-XX

Reference Example 10

9

09

Commonwealth of Massachusetts
MASSHEALTH
MEDICAL SERVICES CLAIM

RETURN TO | MassHealth, P.O. Box 9118, Hingham, MA 02043

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Provider Name
Address
Phone #

1A. BILLING PROVIDER NPI: Billing NPI
1B. BILLING PROVIDER TAXONOMY
1C. RENDERING PROVIDER NPI: Servicing NPI
1D. RENDERING PROVIDER TAXONOMY
2. PAY TO PROVIDER NO.
3. BILLING AGENT NO.
4. PRIOR AUTHORIZATION NO.: if applicable
5. SERVICING PROVIDER'S NAME
6. SERVICING PROVIDER NO.
7. REFERRING PROVIDER'S NAME: MassHealth PCC ONLY
8. REFERRING PROVIDER NO.: PCC referral, if applicable
9. MEMBER'S NAME: member name
10. MEMBER ID NO.: member RID
11. DATE OF BIRTH: DOB
12. SEX: M/F
13. OTHER INSUR.
14. PATIENT ACCOUNT NO.: internal patient acct #
15. PLACE OF SERVICE: 06
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? X NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25.	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO VIS. FL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	120107		Monaural dispensing	V5241LT			1	$ 1500 00	$	
B	120107		Monaural digital BTE	V5257LT			1	334 00		
C	120107		Earmold	V5264			1	47 75		
D	120107		Batteries, 2 packs/8	V5266			16	25 00		
E										
F										
G										
H										
I										
J										

35. REMARKS:

V5257LT invoice cost $317.00* plus shipping ($17.00) = $334.00

V5264 invoice cost $28.00, plus dispensing fee ($13.52) = $41.52, plus 15% out-of-office increase ($6.23) = $47.75

* use the AAC of the base model to determine if P.A. is needed based on cost. If AAC > $500.00, P.A. is required

36. TOTAL USUAL FEE $
37. TOTAL OTHER PAID AMOUNT $

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

38. AUTHORIZED SIGNATURE
39. BILLING DATE

40. ADJUSTMENT
RESUBMITTAL
41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE
B. CODE
C. CODE
D. CODE

1 BM-11/00-G100060

PRINTED ON RECYCLED PAPER

MA-9 (Rev. 09/07)

Reference Example 10

MICROSONIC The Full Service Earmold Laboratory **INVOICE #**

P.O. Box 184 2960 Duss Avenue
Ambridge, PA 15003
(800) 523-7672 (724) 266-9270

Date _____

ACCOUNT NUMBER

BILL TO

Client's Name _____ ☐ Left Ear ☐ Right Ear

PHYSICAL STYLE OPTIONS

2 | Ob Total

Style Number | Style Name (listed above on inside cover)

☐ Tragus ☐ Helix on ☐ Helix off

28.00

ACOUSTIC OPTIONS

VENTING	BORE	LIBBY HORN	CANAL LENGTH
☐Parallel ☐S.A.V.	☐Standard	☐3 mm (medium)	☐Short
☐Diagonal	☐Acoustic Modifier	☐3 mm (thick)	☐Medium
☐External	☐Belled Bore	☐4 mm (standard)	☐Long
☐Small .031	☐Vent Bore		☐As Marked
☐Med. .062		C.F.A. # _____	
☐Large .094	☐High Shine		

MATERIAL OPTIONS

☐A. Acrylic	☐invisi-ear	☐clear	☐tint	☐beige	☐brown
☐B. Super Alerite		☐clear	☐pink		
☐C. Super Alerite w/Silky Silicone Canal		☐clear	☐pink		
☐D. Acrylic Body w/Vinylflex I Canal	☐invisi-ear	☐clear	☐tint	☐beige	☐brown
☐E. Polyethylene		☐pink only			
☐F. Synth-A-Flex II	☐ ear	☐clear	☐tint	☐beige	☐brown
☐G. Vinylflex II	☐In	☐clear	☐tint	☐beige	
☐I. Medi-Sil II		☐clear	☐tint	☐beige	☐brown
☐J. Acrylic Body w/Synth-A-Flex Canal	☐In	☐clear	☐tint		
☐L. M2000	☐inv	☐ear	☐tint	☐beige	☐brown
☐M. M2000 Plus			☐tint	☐beige	☐brown
☐N. M2000 Neon-Lite (Floating Plugs Only) _____			_____ color		
☐U. UV Flex		☐	☐tint		

TUBING OPTIONS

☐# 12 (std.)	☐Single Bend	☐Dri-Tube
☐# 13 (med.)	☐Double Bend	☐Cemented
☐# 13 (thick)	☐Tube-Lock	
☐# 13 (dbl./wall)		
☐# 15 (thick)		

incomplete order will del
incurred if shipping metho
received by noon will be s
choose (except where ind

Mail 1st Class ☐ Mail
DHL 2nd Day ☐ DHL Nex
UPS Ground ☐ UPS 2nd
***SAME DAY LAB REQUE

Any "same day" lab request must be received by noon and will incur an additional $5.00 per order cost.

This impression is not very good. However, we h it for your patient's convenience. Should you need a remake, please take a new impression and send it along with this guarantee. It's been our pleasure to serve you. Thank you.

100 110 RIGHT EAR (O) LEFT EAR (X)

AID GAIN ☐Low ☐High ☐Moderate

EAR CANAL PRESSURE ☐Soft ☐Med. ☐Firm

AID TYPE: ☐Behind Ear ☐Body

IMPAIRMENT ☐Mild ☐Severe ☐Mod. ☐Profound

FITTING INFORMATION ☐New User ☐Old User

OFFICIAL USE ONLY
BS PP+L PS
GS BP+L PCH
YS PUR OTHER

SPECIAL INSTRUCTIONS
If a remake — fill explanation and return original guarantee

Reference Example 10

Siemens Hearing Instruments, Inc.

Please remit to: Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Cust No.	Invoice No.	Inv. Date	TOTAL DUE
			0

To insure proper credit please return remittance stub

Siemens Hearing Instruments, Inc.

10 Constitution Ave.
Piscataway, NJ 08855, USA
(800) 766-4500 Local Call: (732) 562-6600

INVOICE

BILL TO

SHIP TO

ORDERING CLINIC

Customer No.	Customer P.O. No.	Patient Name	Invoice No.

Order No.	Order Date	Terms	Shipment Method	Invoice Date
			DHL OVERNIGHT/NEXT DAY	

Please remit to:
Siemens Hearing Instruments, Inc.
Dept AT 40082
Atlanta, GA 31192-0082, USA

Line Item Numbers	Item Descriptive Information	Qty Ordered	Qty BackOrder	Qty Shipped	WR MO	List Price	Extension	Discounted Price	Invoice Amount
1 10147417	BTE, INTUIS DIR BG 13 BAT	1	0	1	24	506.00	506.00	317.00	317.00
Patient Name		Serial Number	War Exp						

Subtotal	317.00
Tax Amount	0.00
Shipping	17.00
TOTAL	334.00

Prices as stated may not include additional discounts earned through Customer's participation in a Siemens program. It is Customer's responsibility to report accurately the net effective discount price for each product, including all discounts earned through a Siemens program, to third party and others, to the extent required by law. All merchandise remains the property of Siemens Hearing Instruments, Inc. until paid in full. Claims must be made within 7 days after receipt of shipment. Past due invoices are subject to a service charge of 1.5% per month, equal to 18% per year where applicable.