Disclaimer: This is an example form. Please verify and update billing codes as appropriate for your practice setting.

Patient Last Name	First Name		MI
Address	City	State	Zip
Birthdate	SSN		
Date of Service	Diagnosis/Diagnosis Code		

PATIENT AUTHORIZATION

I hereby authorize release of information to health care providers, institutions, and/or payers that may pertain to my illness and/or treatment received. I certify that the information I have reported with regard to my insurance coverage is correct, and I have received and paid for the pharmacist care/services indicated.

Patient Signature Date

PHARMACY SERVICES	**CODE**	**CHARGE**
New CBA Patient Office Visit		
☐ Brief (approx. 10 min)	99201	$______
☐ Expanded (approx. 20 min)	99202	$______
☐ Detailed (30+ min)	99203	$______
Established CBA Patient Office Visit		
☐ Brief (approx. 5 min)	99211	$______
☐ Expanded (approx. 10 min)	99212	$______
☐ Detailed (approx. 15 min)	99213	$______
Preventative Medicine Screening Counseling		
☐ Approx. 15 minutes	99401	$______
☐ Approx. 30 minutes	99402	$______
☐ Approx. 45 minutes	99403	$______
☐ Approx. 60 minutes	99404	$______

IMMUNIZATIONS

Influenza Vaccine		
☐ Split virus vaccine, 6-35 mos.	90687	$______
☐ **Split virus vaccine, 3+ years**	90688	$______
☐ **Administration**	G0008	$______
☐ Other: ________________		$______
☐ Other: ________________		$______
☐ Other: ________________		$______

TOTAL CHARGES $________________

Pharmacy Location/Stamp:

LABORATORY SERVICES	**CODE**	**CHARGE**
☐ Blood Glucose	82948	$______
☐ HbA1c	83036	$______
☐ Lipid Panel	80061	$______
☐ Total Cholesterol	82465	$______
☐ HDL	83718	$______
☐ Triglycerides	84478	$______
☐ ALT	84460	$______
☐ Venipuncture/Fingerstick	36415	$______
☐ Other: ________________		$______
OTHER SERVICES		
☐ Blood Pressure Monitoring	93784	$______
☐ Bone Density Ultrasound	76977	$______
☐ Spirometry/Peak Flow	94010	$______
☐ Educational Supplies	99071	$______
☐ Other: ________________		$______
☐ Other: ________________		$______

Discussion/Additional Information:

I certify that the above services as indicated have been rendered and the fees submitted are the actual fees I have charged to and collected from the patient for those services.

Pharmacist Signature Date

Pharmacist License #

When submitting claims to private insurance, attach Patient Insurance Form and Statement of Medical Necessity or physician referral. ***For Medicare claims, use HCFA-1500 claim form.***

Attention: This form contains PHI, store or dispose according to HIPAA Policies and Procedures