Testimony & Depositions

☐ **99075** Medical Testimony and Depositions (billed per hour)

Date of Testimony/Deposition:

_____ / _____ / _____

Total Hours: _____

Testimony/Deposition Fee:

$ _____

Special DSHS Requested Evaluations

☐ **99199** DSHS Physical Eval form requested by CSO

Fee: **$** _____

Special Services

☐ **99080** Special Reports such as insurance forms

Fee: $ _____

☐ **99199** Unlisted special service, or report

Fee: $ _____

Bill services to the following:

Name:

_____

_____

Address:

_____

_____

City:

_____

State/Zip:

_____ _____

Phone:

Washington State L&I Workers Comp Forms

☐ 1027M LEP - Loss of earning power
☐ 1038M req 1st Rev JA Job Analysis
☐ 1028M " each add Rev JA
☐ 1040M ROA - Rpt of Accident/Injury
☐ 1041M Reopening L&I application
☐ 1046M Mileage >14 miles round trip
☐ 1055M Detailed Occ Dis History
☐ 1057M Opioid Progress Rpt Supp
☐ 1063M req Attg MD rev of IME
☐ 1064M req 1st rpt opioid - chronic
☐ 1068M Ret to Wrk Assess (COHE)
☐ 1070M Ref pt to Occ/Med (COHE)
☐ 1073M APF Activity Presc Form
☐ 1074M req by VRC employers APF
☐ 1190M Att MD IMR - Limited
☐ 1191M " Standard
☐ 1192M " Complex
☐ 1193M Approved Consult IME-Ltd
☐ 1194M " Standard
☐ 1195M " Complex
☐ 99080 Rtp req by L&I or 60 day rpt

** Do not report 99080 in conjunction with 99455, 99456 for the completion of Workers' Comp. forms

Medical Team Conference

30 min or more w/interdisciplinary team of health care professionals

☐ 99366 Face-to-Face w/ patient and/or family w/non phys qualified health care prof
☐ 99367 Patient and/or family not present w/physician
☐ 99368 Patient and/or family not present w/ non phys qualified health care prof

Mail white copy and supporting documentation to:
Attn: UWP Outpatient Charge Capture
Box 359110
Keep the pink copy of the fee sheet for your records.

Check Enclosed: ☐ No ☐ Yes

Check Amount: $ _____

Check Number:

Telephone & Online Services

☐ 99441 Phone E&M service by a phys to an est. patient, parent or guardian, 5-10 minutes of med. discussion.
☐ 99442 " 11-20 minutes of med. discussion.
☐ 99443 " 21-30 minutes of med. discussion.
☐ 99444 Online E&M by phys to est patient not originating from related E&M visit
☐ 98966 Phone assessment & management service by a qualified non-phys health care prof, 5-10 min of med discussion.
☐ 98967 " 11- 20 minutes of medical discussion.
☐ 98968 " 21-30 minutes of med. discussion.

Nursing Facility Services

Nursing Facility, Intermediate Care or Long Term Facilities

NF Discharge Services

☐ 99315 Disc. Day Mgmt 30 min <
☐ 99316 Disc. > 30 min

Name of Skilled Nursing Facility:

*(Required for billing SNF services)

Home Services

Physician Services provided in a private residence

New Patient face-face

☐ 99341 Level 1 20 min
☐ 99342 Level 2 30 min
☐ 99343 Level 3 45 min
☐ 99344 Level 4 60 min
☐ 99345 Level 5 75 min

Established Patients face-face

☐ 99347 Level 1 15 min
☐ 99348 Level 2 25 min
☐ 99349 Level 3 40 min
☐ 99350 Level 4 60 min

Basic Life/Disability Eval.

☐ 99450 Basic Life/Disability Eval

Fee: $ _____

☐ 99455 ** Work Related or Med. Disability Exam by treating physician.

Fee: $ _____

☐ 99456 ** Work Related or Med. Disability Exam by non-treating physician.

Fee: $ _____

** Do not report 99080 in conjunction with 99455, 99456 for the completion of Workers Comp. forms

Home Health Certifications for Medicare patients

☐ G0180 Physician certification for Medicare-covered home health services (patient not present) per certification period.
☐ G0179 Physician re-certification for Medicare-covered home health services (patient not present) per certification period.
☐ G0181 Physician supervision of a patient receiving Medicare-covered services provided by a HHA (patient not present) > 30 minutes per month.
☐ G0182 Physician supervision of a patient under a Medicare-approved hospice.

Medicare-approved Home Health Agency Provider #

_____

(*Required for billing cert. services)

Care Plan Oversight

From Date: _____

To Date: _____

Home, Domicili. Or Equiv. environment

☐ 99374 15-29 mins. per month
☐ 99375 > 30 mins. per month

Nursing Facility (Not paid by Medicare)

☐ 99379 15-29 mins. per month
☐ 99380 > 30 mins. per month

Critical Care Services

Physician attended interfacility transport of a critically ill or critically injured patient over 24 months of age.

☐ 99291 First 30-74 minutes

☐ 99292 Each addl. 30 minutes

Notes:

X	CPT Code	Mod	Write in Description of Procedure or Supply	UWP Fee

Diagnosis

	ICD-9 CODE	Write in description of diagnoses		ICD-9 CODE	Write in description of diagnoses
1st			2nd		

Date _____

Pt. No. _____

Name _____

DOB _____

Special Sponsor _____

Budget # _____

Referring or Ordering Physician/Practitioner	Med. Staff ID or MPI
Performing Physician/Practitioner	Med. Staff ID or MPI

I certify that the services shown were furnished by me personally or under my personal supervision.

☐ **COHE Provider**

UWP Billing Physician/Practitioner	UWP /Med. Staff ID

UWP Service Area