CHIROPRACTIC WELLNESS CLINIC

Phone:..... Email:

SUPERBILL / INVOICE

Date of Invoice:

Invoice Number:

PATIENT INFORMATION

Patient Name:

Date of Birth:..... Gender:

Address:

Phone:

Insurance Co:

Policy / ID No:..... Group No:

PROVIDER & CLINIC DETAILS

Provider Name:

Clinic Tax ID:

Provider NPI:

State License #:

Referring Phys:

Date of Service:

DIAGNOSIS CODES (ICD-10)

- ☐ M54.2 Cervicalgia
- ☐ M54.6 Pain in Thoracic Spine
- ☐ M54.50 Low Back Pain
- ☐ M54.16 Radiculopathy, Lumbar
- ☐ M99.01 Subluxation, Cervical
- ☐ M99.02 Subluxation, Thoracic
- ☐ M99.03 Subluxation, Lumbar
- ☐ M99.04 Subluxation, Sacral
- ☐ G44.2 Headaches
- ☐ M79.1 Myalgia
- ☐ M25.50 Joint Pain
- ☐ Other: _____

SELECT	CPT CODE	DESCRIPTION OF SERVICE	MODIFIER	UNITS	FEE ($)	TOTAL ($)
☐	99202	E/M New Patient - Brief (Level 2)				
☐	99203	E/M New Patient - Moderate (Level 3)				
☐	99212	E/M Established Patient - Brief (Level 2)				
☐	99213	E/M Established Patient - Moderate (Level 3)				
☐	98940	Chiropractic Manipulative Tx (CMT) - Spinal, 1-2 Regions				
☐	98941	Chiropractic Manipulative Tx (CMT) - Spinal, 3-4 Regions				
☐	98942	Chiropractic Manipulative Tx (CMT) - Spinal, 5 Regions				
☐	98943	Chiropractic Manipulative Tx (CMT) - Extraspinal, 1+ Regions				
☐	97110	Therapeutic Procedure / Exercises (per 15 min)	GP			
☐	97140	Manual Therapy Techniques (per 15 min)	GP			
☐	97014	Electrical Stimulation (unattended)	GP			

SELECT	CPT CODE	DESCRIPTION OF SERVICE	MODIFIER	UNITS	FEE ($)	TOTAL ($)
☐	97010	Hot / Cold Pack Application	GP			
☐						

Patient/Provider Statement:
I hereby certify that the services listed above were medically necessary and personally rendered by me or under my direct supervision. I authorize the release of any medical information necessary to process this claim.

Total Charges:

Amount Paid:

Balance Due:

Provider Signature

Date:

Patient / Representative Signature

Date: