

CASE STUDY 1-2**I. M. Gayle encounter form****SEJAL RAJA, M.D.****Encounter Form**

1 Medical Drive ■ Injury US 12347 ■ (101) 202-2923

EIN: 11-139799 CONN GEN PIN: SR9919

MCD: SR2995 BCBS PIN: 994321

PATIENT INFORMATION:

Name: I. M. Gayle
 Address: 101 Happy Drive
 City: Anywhere
 State: US
 Zip Code: 12345
 Telephone: (101) 111-9876
 Gender: Female
 Date of Birth: 09-30-1945
 Occupation: Clerk
 Employer: Mail Boxes, Inc.
 Spouse's Employer:

INSURANCE INFORMATION:

Patient Number: 1-2
 Place of Service: Office
 Primary Insurance Plan: Conn General
 Primary Insurance Plan ID #: 210010121
 Group #: 101
 Primary Policyholder: I. M. Gayle
 Policyholder Date of Birth: 09-30-1945
 Relationship to Patient: Self
 Secondary Insurance Plan:
 Secondary Insurance Plan ID #:
 Secondary Policyholder:

Patient Status Married Divorced Single Student Other

DIAGNOSIS INFORMATION

Diagnosis	Code	Diagnosis	Code
1. Numbness, left arm	782.0	5.	
2. Osteoarthritis, cervical	715.98	6.	
3.		7.	
4.		8.	

PROCEDURE INFORMATION

Description of Procedure or Service	Date	Code	Charge
1. Office visit, established patient, level III	03-01-YYYY	99213	60.00
2. Trigger point injection, trapezius, left upper & mid	03-01-YYYY	20552	75.00
3.			
4.			
5.			

SPECIAL NOTES:

Patient paid \$50 of today's total.

CASE STUDY 1-4**Jeffrey A. Green encounter form****SEJAL RAJA, M.D.****Encounter Form**

1 Medical Drive ■ Injury US 12347 ■ (101) 202-2923

EIN: 11-139799 CONN GEN: SR9919

MCD: SR2995 BCBS PIN: 994321

PATIENT INFORMATION:

Name: Jeffrey A. Green
Address: 103 Mountain View Road
City: Nowhere
State: US
Zip Code: 12367
Telephone: (101) 117-8765
Gender: Male
Date of Birth: 02-03-1987
Occupation:
Employer:
Father's Employer: Self-employed
Mother's Employer: Goodmedicine Clinic

INSURANCE INFORMATION:

Patient Number: 1-4
Place of Service: Office
Primary Insurance Plan: BCBS
Primary Insurance Plan ID #: XWV7794483
Group #: 876
Primary Policyholder: Jeffrey G. Green
Policyholder Date of Birth: 07-01-1955
Relationship to Patient: Father
Secondary Insurance Plan: BCBS
Secondary Insurance Plan ID #: XWV21928
Secondary Policyholder: Janine Green
Relationship to Parent: Mother
Policyholder Date of Birth: 12-24-1957

Patient Status Married Divorced Single Student Other

DIAGNOSIS INFORMATION

Diagnosis	Code	Diagnosis	Code
1. Acute bronchitis	466.0	5.	
2. Purulent rhinitis	472.0	6.	
3.		7.	
4.		8.	

PROCEDURE INFORMATION

Description of Procedure or Service	Date	Code	Charge
1. Office visit, established patient, level II	03-10-YYYY	99212	26.00
2.			
3.			
4.			
5.			

SPECIAL NOTES:

Patient's mother paid \$15 of today's total. Return visit prn.

CASE STUDY 1-6**Elaine Blueberry encounter form****IRMINA M. BRILLIANT, M.D.**

25 Medical Drive ■ Injury US 12347 ■ (101) 201-3145

EIN: 11-765431

TRICARE PIN: IBM7791

UPIN: IB9821

BCBS PIN: 99531

Encounter Form**PATIENT INFORMATION:**

Name: Elaine Blueberry
 Address: 101 Bust St
 City: Anywhere
 State: US
 Zip Code: 12345
 Telephone: (101) 555-5689
 Gender: Female
 Date of Birth: 10-02-1925
 Occupation:
 Employer:
 Spouse's Employer:

INSURANCE INFORMATION:

Patient Number: 1-6
 Place of Service: Inpatient Hospital
 Primary Insurance Plan: Medicare
 Primary Insurance Plan ID #: 102 62 3434B
 Group #:
 Primary Policyholder: Elaine Blueberry
 Policyholder Date of Birth: 10-02-1925
 Relationship to Patient: Self
 Secondary Insurance Plan: BCBS Medigap
 Secondary Insurance Plan ID #: XWY123456
 Secondary Policyholder: Elaine Blueberry

Patient Status Married Divorced Single Student Other

DIAGNOSIS INFORMATION

Diagnosis	Code	Diagnosis	Code
1. Gastrointestinal bleeding	578.9	5.	
2. Perianal rash	691.0	6.	
3.		7.	
4.		8.	

PROCEDURE INFORMATION

Description of Procedure or Service	Date	Code	Charge
1. Inpatient consultation, level III	03-01-YYYY	99253	125.00
2.			
3.			
4.			
5.			

SPECIAL NOTES:

Care rendered at Goodmedicine Hospital, Provider Street, Anywhere US 12345. Admission Date: 03-01-YYYY. Discharge Date: 03-05-YYYY. Referring provider: I. M. Gooddoc, M.D. (SSN: 777707070)

CASE STUDY 1-10**Gladys Phish encounter form**

ANGELA DILALIO, M.D.		Encounter Form	
99 Provider Dr ■ Injury US 12347 ■ (101) 201-4321			
EIN: 11-198234	TRICARE PIN: ADL1982		
UPIN: AD9101	BCBS PIN: 991234		
PATIENT INFORMATION:		INSURANCE INFORMATION:	
Name:	Gladys Phish	Patient Number:	1-10
Address:	21 Windwhisper Dr	Place of Service:	Hospital Outpatient Dept.
City:	Injury	Primary Insurance Plan:	Medicare
State:	US	Primary Insurance Plan ID #:	101891701A
Zip Code:	12347	Group #:	
Telephone:	(101) 111-2397	Primary Policyholder:	Gladys Phish
Gender:	Female	Policyholder Date of Birth:	11-21-1930
Date of Birth:	11-21-1930	Relationship to Patient:	Self
Occupation:		Secondary Insurance Plan:	
Employer:		Secondary Insurance Plan ID #:	
Spouse's Employer:		Secondary Policyholder:	
Patient Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Student <input type="checkbox"/> Other			
DIAGNOSIS INFORMATION			
Diagnosis	Code	Diagnosis	Code
1. Cellulitis, right hand	682.4	5.	
2.		6.	
3.		7.	
4.		8.	
PROCEDURE INFORMATION			
Description of Procedure or Service	Date	Code	Charge
1. Incision & drainage, abscess, subcu.	03-10-YYYY	10060	450.00
2.			
3.			
4.			
5.			
SPECIAL NOTES:			
Hospital Info: Goodmedicine Hospital, 1 Provider St, Anywhere US 12345.			
Referring provider: I. M. Gooddoc, M.D. UPIN: IG7771. Admission/Discharge Date: 03-10-YYYY.			