Professional Intracept Claim Form

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Black = Required
Blue = Situational/Required, if applicable

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) ☒ / MEDICAID (Medicaid#) ☐ / TRICARE (ID#/DoD#) ☐ / CHAMPVA (Member ID#) ☐ / GROUP HEALTH PLAN (ID#) ☐ / FECA BLK LUNG (ID#) ☐ / OTHER (ID#) ☐	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Jones, Macie	3. PATIENT'S BIRTH DATE MM DD YY: 02 01 1961 — SEX: M ☐ F ☒
5. PATIENT'S ADDRESS (No., Street): 27 Wyoming Drive	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
CITY: New Richmond — STATE: WI	8. RESERVED FOR NUCC USE
ZIP CODE: 54071 — TELEPHONE (Include Area Code): (651)555-5555	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☒
d. INSURANCE PLAN NAME OR PROGRAM NAME: Medicare	10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: None	CARRIER
a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐	PATIENT AND INSURED INFORMATION
b. OTHER CLAIM ID (Designated by NUCC)	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on file — DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on file

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Timothy Jones	17a. — 17b. NPI 0123456789
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJU: A. M54.51 B. C. D. E. F. I. J.	22. RESUBMISSION CODE — ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: A123456789

Enter place of service code:
24 – Ambulatory Surgery Center
22 – On Campus Outpatient Hospital

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 07 22	01 07 22			64628		A	XXXX	1		NPI	1234567890
2 01 07 22	01 07 22			64629		A	XXXX	1-2		NPI	1234567890
3											
4											
5											
6											

PHYSICIAN OR SUPPLIER INFORMATION

64628 – Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; **first two vertebral bodies**, lumbar or sacral.
64629 - Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; **each additional vertebral bodies**, lumbar or sacral.

25. FEDERAL TAX I.D. NUMBER: 123456789 SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $ XXXX	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: Main Street Hospital, 12345 Main Street, New Richmond WI 54071 — a. NPI — b.
	33. BILLING PROVIDER INFO & PH #: Dr. John Smith, 1234 Main Street, New Richmond WI 54071 — a. NPI — b.

NUCC Instruction Manual available at: www.nucc.org — ***PLEASE PRINT OR TYPE*** — APPROVED OMB-0938-1197 FORM 1500 (02-12)

This claim form is a sample only and not a guarantee of claim payment

Indications for Use: The IntraceptTM Intraosseous Nerve Ablation System is intended to be used in conjunction with radiofrequency (RF) generators for the ablation of basivertebral nerves of the L3 through S1 vertebrae for the relief of chronic low back pain of at least six months duration that has not responded to at least six months of conservative care, and is also accompanied by features consistent with Type 1 or Type 2 Modic changes on an MRI such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals (Type 2 Modic change). Contraindications - Use of the Intracept Intraosseous Nerve Ablation System is contraindicated in: Patients with severe cardiac or pulmonary compromise, patients with active implantable pulse generators (e.g. pacemakers, defibrillators), patients where the targeted ablation zone is < 10 mm away from a sensitive structure not intended to be ablated, including the vertebral foramen (spinal canal), patients with active systemic infection or local infection in the area to be treated, patients who are pregnant, and/or skeletally immature patients (generally ≤ 18 years of age). Refer to the Instructions for Use provided with the Intracept Procedure or www.relievant.com/intracept/ for potential adverse effects, warnings, and precautions prior to using this product.

Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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