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**Apple Drugs Diabetes Center/Core Clinical Care, LLC.**

 **Invoice for Educational Services**

Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE**

 **Beneficiary ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service G0-108** Individual \_\_\_\_\_\_\_\_\_\_ x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Service G0-109** Group \_\_\_\_\_\_\_\_\_\_ x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medicare Annual Follow up:**

**Service G0-108** Individual \_\_\_\_\_\_\_\_\_\_ x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service G0-109** Group \_\_\_\_\_\_\_\_\_\_ x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMERCIAL**

**Beneficiary ID Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service 98960** (Individual) \_\_\_\_\_\_x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service 98961** (Group 2-4 patients) \_\_\_\_\_\_x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Service 98962** (Group 5+ patients) \_\_\_\_\_\_x 30 minutes Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Submitted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits:** I hereby assign all insurance benefits and payments to be made directly **Apple Drugs Diabetes Center/Core Clinical Care, LLC.** for any services furnished to me. I authorize **Apple Drugs Diabetes Center/Core Clinical Care, LLC** to seek such benefits and payments on my behalf. It is understood that, as a courtesy, **Apple Drugs Diabetes Center/Core Clinical Care, LLC** will bill Medicare / CareFirst providing coverage exists. I understand that I am responsible for providing all necessary information and for making sure that all certification and enrollment requirements for insurance and benefits are fulfilled. Any changes in insurance and benefits must be reported to **Apple Drugs Diabetes Center/Core Clinical Care, LLC** within 30 days of the event. I have been informed by **Apple Drugs Diabetes Center/Core Clinical Care, LLC** of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I may be fully responsible for payment.

**Financial Responsibility:** I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, copayments, out of pocket requirements, and non-covered services period. If for any reason and to any extent, **Apple Drugs Diabetes Center/Core Clinical Care, LLC** does not receive payment from any payer source, I hereby agree to pay **Apple Drugs Diabetes Center/Core Clinical Care, LLC** for the balance in full within 30 days of receipt of invoice. By signing below, I agree the above services were provided to me and I further agree that I am responsible for the charges listed above. Should it become necessary to turn my account over to an attorney / collection agency, I agree to pay a collection fee of 33% of the balance then due.

**Insurance Statement:** Benefits quoted by the insurance company to **Apple Drugs Diabetes Center/Core Clinical Care, LLC** at the time of service is provided is **NOT** a guarantee of payment, deductible or co-payment but rather is subject to review by the insurance company.

Beneficiary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Community Pharmacy Foundation | GTwigg - Grant #143 | <http://www.communitypharmacyfoundation.org/grants/grants_list_details.asp?grants_id=70981> |