As the patient's physician, Medicare and some private insurers allow you to bill for overseeing your hospice patient's care plan, as well as advanced care planning. This includes completion of advanced directives such as MOLST (billing code 99497) and end-of-life discussions (billing code 99498).

You may bill for up to 30 minutes for these discussions and you may bill as needed or when a patient has a significant change in condition.

Call 845-485-2273 or fax 845-790-0009 with any questions or referrals.

**Hospice Patient Billing Guide**
(Form 1500)

**Date of Service:**
Date of physician's Certification (Signature) on the 485.

**Place of Service:** Office 11

**Type of Service:** 01

**CPT Code:** G0182

**Modifier:**
- GV (attending physician)
- Q5 covering physician; used in conjunction with GV
- Q6 locum tenens physician; used in conjunction with GV
- GW (service not related to terminal condition)

**Hudson Valley Hospice's Provider Number is:** 331521 (Enter in Box 23)

**Charge:** G0182 for Care Plan Oversight - Hospice

**Diagnosis:** 485 Plan of Care

**Note:**
Remember to retain a copy of the signed HCFA-485 (Hospice Plan of Care), all signed interim or telephone orders and any reports of patient status used to certify or recertify patient.
HEALTH INSURANCE CLAIM FORM

1. M EDICARE   M EDICAID   C HAMPUS   C HAMPVA   G ROUP   H EALTH PLAN (SSN or ID)   F ECA   B LK LUNG (SSN)   A NOTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S ADDRESS (No., Street)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S BIRTH DATE

7. INSURED'S ADDRESS (No., Street)

8. PATIENT'S STATE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

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.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE

PLACE OF SERVICE

PROCEDURES, SERVICES, OR SUPPLIES

EXPLAIN UNUSUAL CIRCUMSTANCES

MODIFIER

DIAGNOSIS CODE

$ CHARGES

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

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.

PLEASE PRINT OR TYPE