Dr James R. Dugue, O.D.
25982 Pala Suite 270
Mission Viejo, CA 92691

We are happy to bill your insurance company for your visit. Please fill out this form so that we can submit your bill to your insurance company. ***If you are insured by an HMO, you are responsible for payment of all medical services rendered.***

Name of Patient:_____Birthdate:_____

Insurance ID Number : _____

Name of insured:(if different)_____ Birthdate: _____

Insurance ID Number: _____

Employer (of insured):_____

Patient relationship to insured: Self___Spouse___Child___Other___

I authorize the release of medical or other information necessary to process this claim.

Signed:_____(patient or guardian) Date:_____

I authorize payment of medical benefits to Dr. Dugue.

Signed : _____ (Insured) Date_____

For Office Use: Date of Service:_____

Insurance Authorization Number:_____

Service	CPT	Fee		Service	CPT	Fee
New OV: prob	99201	49		EST EXAM comp	92014	89
New OV: expand prob	99202	59		Refraction	92015	39
New OV: low cmp	99203	79		Ext Ophthmal	92225	55
New OV: med cmp	99204	89		Ext Visual Field	92083	100
New OV: hi cmp	99205	109		Fundus Photography	92250	65
EST OV: f/u	99211	49		FBR/FU corneal	65222	90
EST OV: prob focused	99212	59		FBR/FU conjunct	65205	90
EST OV: low cmp	99213	79		Serial Tonometry	92100	55
EST OV: med cmp	99214	89		Pachymetry	76514	29
EST OV: hi comp	99215	109		CL Fit Specialty	92310	99
New EXAM interm	92002	69		CL Fit	92311	79
New EXAM comp	92004	89		Gonioscopy	92020	45
EST EXAM interm	92012	69		Epilation	67820	95