BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois Provider Manual

Home Infusion Section

2016

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Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any.

Home Infusion Therapy Guidelines

The information in this section is provided as a supplement to the Blue Cross and Blue Shield of Illinois (BCBSIL) Contract Agreement with Home Infusion Therapy (HIT) providers to familiarize providers with BCBSIL policies concerning HIT, particularly billing of services. All HIT providers are required to abide by these BCBSIL policies and are accountable to deliver services and bill accordingly on a CMS 1500 claim form. Electronic billing of claims is required. In addition, all HIT providers must be accredited by one of the nationally recognized accreditation organizations (Joint Commission, ACHC or CHAP) in order to contract with BCBSIL.

Drugs considered as self-injectable may be considered eligible for benefits under the BCBSIL member's drug prescription card in most cases, and may not be delivered or billed by the HIT provider.

Specialty Pharmacy injectable/infusible medications may be required to treat complex medical conditions such as growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis. BCBSIL has contracted with independent specialty pharmacies for these medications. The list of these medications and contracted specialty pharmacies' contact information may be found at http://www.bcbsil.com/provider/pharmacy/specialty_pharmacy.html.

Many intravenous/injectable therapies will have specific medical necessity criteria in order to be eligible for benefits. All providers are encouraged to review relevant BCBSIL Medical Policies, which are located in the Standards and Requirements section of the BCBSIL Provider website, prior to rendering services. It may be appropriate for BCBSIL non-HMO members to complete a Predetermination Request Form, which is located in the Education and Reference section. The Predetermination Request Form may be submitted along with the appropriate medical necessity documentation, as required.

Services normally considered eligible for benefits

Intravenous (IV) solutions and/or injectable medications may be considered eligible for benefits under the criteria for medical necessity if all of the following are met:

1. Prescription drug is U.S. Food and Drug Administration (FDA) approved or meets benefit criteria for off-label use;

2. The provision of services in the home is not primarily for the convenience of the member, the member's caregivers or the provider;

3. Therapy is managed by a physician as part of a treatment plan for a covered medical condition;

4. Home care is provided by a home health care agency or a specialized home infusion company; and

5. Infusion in the home must be safe and medically appropriate.

Description

Home infusion and injectable therapy involves the administration of:

- Nutrients
- Medications
- Solutions

These items may be administered intravenously, intramuscularly, enterally, subcutaneously or epidurally.

Infusion therapy originates with a prescription from a physician who is overseeing the care of the member and is designed to achieve physician defined beneficial outcomes.

Specific therapies provided may include, but are not limited to:

- Anti-infectives
- Blood transfusions
- Chemotherapy
- Immunosuppressive therapy
- Hydration therapy
- Immunotherapy
- Inotropic therapy
- Pain management
- Parenteral and enteral nutrition (refer to BCBSIL Medical Policy Alternative Modes of Nutrition in the Outpatient and Home Setting)
- Tocolytic therapy

Pre-certification Requirements

Many benefit plans require notification and approval prior to rendering any home infusion services. Providers should inquire whether benefit pre-certification is necessary when checking the member's eligibility and benefits.

Most benefit plans require members to utilize in-network providers to obtain maximum benefits. Home Infusion Therapy companies wishing to participate contractually as a PPO/HMO provider must be accredited by a nationally recognized accrediting organization and be state-licensed as a retail pharmacy.

Please refer to the Benefit Prior Authorization section of this manual for information and procedures on pre-certification.

Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any.

Note for HMO Members: All services must have MG/IPA* approval. The PCP must authorize all referrals to home infusion therapy providers within the independently contracted HMO network.

*Medical Group/Independent Practice Association

Billing Guidelines

All claims must be submitted with the appropriate National Drug Code (NDC) with total units of measurement dispensed as well as the HCPCS drug code with appropriate units (per the description of the HCPCS code) per the dosage ordered and administered.

Here are some guidelines for appropriate submission of valid NDCs and related information:

- Submit the NDC along with the applicable HCPCS or CPT procedure code(s)
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters)
- The NDC must be active for the date of service
- The appropriate qualifier, unit of measure, number of units and price per unit also must be included, as indicated below

Electronic Claims Guidelines

Field Name	Field Description	ANSI (Loop 2410) – Ref Desc
Product ID Qualifier	Enter **N4** in this field.	LIN02
National Drug CD	Enter the 11-digit NDC (without hyphens) assigned to the drug administered.	LIN03
Drug Unit Price	Enter the price per unit of the product, service, commodity, etc.	CTP03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given. (Values: **F2** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit)	CTP05-1

Paper Claims Guidelines
In the **shaded portion** of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4** (left-justified), immediately followed by the NDC. Next, enter the appropriate qualifier for the correct dispensing unit (**F2** – international unit; **GR** – gram; **ML** – milliliter; **UN** – unit), followed by the quantity and the price per unit, as indicated in the example below. (The HCPCS/CPT code corresponding to the NDC is entered in field 24D)

Example:

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. #
N400409475563 ML2 12.82													N	1B	12345678901
09	01	14	09	07	14	11		J2405		1	25 64	4	N	NPI	0987654321

New drugs without a valid HCPCS code should be billed using the HCPCS code J3490 or J3590, as applicable, with the appropriate NDC number and units ordered and administered.

Physician orders must include:
- Date of order
- Member name and address
- Diagnosis warranting infusion therapy treatment
- Name of drug, dosage, administration route, frequency of administration and duration of treatment
- Physician name, address and telephone number
- Physician signature and date

Infusion therapy supplies should be billed utilizing the appropriate per diem HCPCS codes (S codes) for the specific drug or drug category. All per diem codes are inclusive of the following:
- Administrative services
- Professional pharmacy services
- Care coordination
- Delivery
- All necessary supplies and equipment
- IV solutions and diluents

The per diem HCPCS code must be billed on the same claim as the corresponding drug for the same dates of service. Modifiers SH (second concurrently administered infusion therapy) and SJ (third or more concurrently administered infusion therapy) must be indicated with the HCPCS code, as appropriate. Reimbursement for the second or subsequent concurrent infusion of same therapy class will be at 50 percent of normal per diem for that code.

Nursing visits may only be billed, electronically or on a UB-04 claim form, by a licensed home health agency with a BCBSIL Coordinated Home Care agreement.

When the member is under a plan of treatment and the Blue Cross Coordinated Home Care benefit, **non-Specialty Pharmacy** injectable/infusible medications and supplies may be billed electronically on a UB-04 claim form with the skilled nursing visits utilizing your National Provider Identifier (NPI) number.

Specialty Pharmacy medications, including but not limited to immunoglobulin may **not** be billed on a UB-04 claim form under the Blue Cross Coordinated Home Care benefit. See BCBSIL contracted Specialty Pharmacies with a listing of specialty drugs at http://bcbsil.com/provider/pharmacy/specialty_pharmacy.html.

When the member is not under the Blue Cross Coordinated Home Care benefit, all home infusion medications and supplies must be billed on the CMS-1500 form or electronically utilizing the provider NPI number.

All providers are encouraged to review relevant BCBSIL Medical Policies, located in the Standards and Requirements section of the BCBSIL Provider website, prior to rendering services. It may be appropriate in some cases to complete a Predetermination Request Form, which is located in the Education and Reference Center/Forms section, and which may be submitted along with the appropriate medical necessity documentation, as required.

Home Infusion Therapy Billing Example

Non-Specialty pharmacy home infusion agents and supplies are billed electronically or on a UB-04 claims form with the skilled nursing visits when the member is under a plan of treatment and the BCBSIL Coordinated Home Care benefit.

The first billing example on the following page demonstrates the method used to bill home care nursing visits and the non-specialty pharmacy IV medication and supplies utilized in administering the drug during the nursing visits.

The second and third billing examples demonstrate the method used when the home infusion provider is acting as the supplier of the infusion agents and supplies only (i.e., not under the Coordinated Home Care benefit.)

Note: BCBSIL reserves the right to update these guidelines as necessary. Providers should review the guidelines posted in the BCBSIL Standards and Requirements section on the BCBSIL Provider website periodically to ensure compliance.

Billing Example 1

1 Home Infusion Agency
123 Main Street
Anytown, IL 60000
312-123-4567

2 Home Infusion Agency
P.O. Box 123
My Town, IL 60000

3a PAT. CNTL # 09917765
b. MED. REC. # 07765
4 TYPE OF BILL 321
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 010316 THROUGH 011616
7

8 PATIENT NAME a Doe, Jane
b
9 PATIENT ADDRESS a 456 Main Street
b Anytown c IL d 60000 e 5999

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
01011958	F	010316			1		30													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	010316													

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	Vancomycin	J3370		48	489 00		
2	264	IV Perdiem	S9501		14	1120 00		
3	551	SN Visits	99341	010311	1	250 00		
4	551	SN Visits	99349	010411	1	150 00		
5	551	SN Visits	99349	010611	1	150 00		
6	551	SN Visits	99349	010911	1	150 00		
7	551	SN Visits	99349	011111	1	150 00		
8	551	SN Visits	99349	011611	1	150 00		
9								
10	001	Total				2609 00		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	020116	TOTALS	2609 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
A	Blue Cross 121					
B						
C						

56 NPI 9876054321
57 OTHER PRV ID

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane	18	XOC123456789	XYZ Company	P02600
B					
C					

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX B95.8 E11.622 B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75

76 ATTENDING NPI 9876054321 QUAL
LAST Smith FIRST Michael
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Billing Example 2

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 [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): R1234567

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

3. PATIENT'S BIRTH DATE: 01 01 1957 SEX: M [X] F [ ]

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

5. PATIENT'S ADDRESS (No., Street): 456 Main St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 456 Main St.

CITY: Anytown STATE: IL

8. RESERVED FOR NUCC USE

CITY: Anytown STATE: IL

ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 123-4567

ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 123-4567

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: FEP

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: 02 02 1956 SEX: M [ ] F [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBSIL

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 02 01 2016 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dennis Lobber

17a.

17b. NPI 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. K90.9 B. D53.9 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 02 01 16	02 07 16			S9365		5793	2165 16	7		NPI	0987654321
N400002821501 ML 16.85											
2 02 01 16	02 07 16			J1815		5793	12 43	20		NPI	0987654321
3 02 01 16	02 07 16			B4185		5793	1120 00	7		NPI	0987654321
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 321234567 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 3405 59

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 Mary Biller DATE 02/11/16

32. SERVICE FACILITY LOCATION INFORMATION
Home Infusion
123 Main Street
Anytown, IL 60000
a. 0987654321 b.

33. BILLING PROVIDER INFO & PH # (312) 555-2667
Hometown Infusion
PO Box 123
Mytown, IL 60000
a. 0987654321 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Billing Example 3

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 X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
							XOF234567890		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M	F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Doe, Jane			01 01 1954				Doe, John		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
456 Main St.			Self	Spouse X	Child	Other	456 Main St.		
CITY		STATE	8. RESERVED FOR NUCC USE				CITY		STATE
Anytown		IL					Anytown		IL
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
60000	(312) 123-4567						60000	(312) 123-4567	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
							P00001		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
			YES	X NO			02 02 1952	M X	F
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)		
			YES	X NO					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES	X NO			BCBSIL		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES X 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 _____ 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
12 31 2015 QUAL.			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
Dennis Lobber	17b. NPI 1234567890		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. M86.10 B. C. D.			
E. F. G. H.		23. PRIOR AUTHORIZATION NUMBER	
I. J. K. L.			

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 01 16 01 07 16	12		J3260		730.27	72 15	13		NPI	0987654321
N400409357801 ML 13.89										
2 01 01 16 01 07 16	12		S9500		730.27	380 00	7		NPI	0987654321
N46791900401 UN3 299.00										
3 01 01 16 01 07 16			J0878		730.27	2775 00	15		NPI	0987654321
4 01 01 16 01 07 16			S9500	SH	720.27	540 00	7		NPI	0987654321
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
321234567		X		X YES NO	$ 1225 00	$	

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (312) 555-2667
SIGNED Mary Biller DATE 01/10/16	Home Infusion 123 Main Street Anytown, IL 60000 a. 0987654321 b.	Hometown Infusion PO Box 123 Mytown, IL 60000 a. 0987654321 b.

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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION