ncATp
North Carolina
Assistive Technology Program

# MEDICAL BILLING FORM

**SECTION 1**

Date Prepared: _____

Patient Name: _____ **(As shown on Medicaid Card)**

Patient Medicaid ID #: _____

Insurance Cards: **(Copies of all cards must be attached.)**
☐ Medicaid - (Front & Back)
☐ Other Health Insurance - (Front & Back)

**SECTION 2**

**PHYSICIAN ORDER FOR EVALUATION: (A Prescription May Be Attached in Lieu of Information Below.)**

I am requesting an augmentative communication evaluation of the patient indicated above in order to determine functional communication needs based on the patient's expressive communication diagnosis.

Name (print): (Doctor) Practice:

Address: City: State: Zip:

Phone:

Signature: NPI #: Date:

**SECTION 3**

**CAROLINA ACCESS:** ☐ YES ☐ NO

Physician's Group Name: _____ Phone Number: _____

Physician's Group NPI #: _____

**SECTION 4**

**OTHER HEALTH INSURANCE: (Must be contacted prior to service - If Applicable)**

☐ YES ☐ NO

**Company:** _____ **Insured ID #:** _____ **Policy/Group #:** _____

**Prior Approval Required?:** ☐ NO ☐ YES. Prior Approval Attached ☐ YES. Reference # _____

**CMS 1500 Claim Form Information:**

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Employer: _____ ** (Insured is the policy holder)

**SECTION 5**

**REFERRAL PACKET MUST INCLUDE:**

1. **NCATP Referral for Services Form**
2. **Medical Billing Form with attachments as indicated above**
3. **Financial Policy Form**

**MAIL COMPLETED PACKET TO:**

Intake Coordinator
NCATP
4900 Waters Edge Drive, Suite 250
Raleigh, NC 27606-2395

Phone #: (919) 233-7075
Fax #: (919) 233-7081
**(If faxes exceed 25 pages original must be mailed.)**

**SECTION 6**

**CONTACT INFORMATION FOR REFERRING PARTY:**

**Name:** _____

**Job Title/Agency:** _____

**Phone & Fax :** _____

**E-Mail:** _____

**Revised 4-20-2012**