☐ 11605 N. Kendall Drive
Miami, FL 33176
Office: (305) 982-8927
Fax: (305) 647-6120

☐ 2873 Stirling Road
Ft.Lauderdale, FL 33312
Office:(954) 983-4969
Fax:(954) 983-1770

☐ 1770 W. 32nd Place
Hialeah, FL 33012
Office:(305) 885-4477
Fax:(305) 885-2396

ADVANCED VISION CARE

☐ Midway Plaza
5865 N.University Drive
Tamarac, FL 33321
Office:(954) 720-9201
Fax:(954) 726-6457

☐ 246 S.Flamingo Road
Pembroke Pines, FL 33027
Office:(954) 443-1230
Fax:(954) 443-1234

☐ 3682 W.Oakland Park Blvd.
Lauderdale Lakes, FL 33311
Office:(954) 730-8087
Fax:(954) 730-7201

☐ **Dr. Amir Cukierman** ☐ **Dr. Michael Gomez** ☐ _____ Date ____ / ____ / ____

Name _____ Sex ____ Birthdate _____

Address _____ City _____ State ____ Zip _____

Home Phone # _____ Insurance Plan _____

I.D Number _____ Authorization Number _____

PROCEDURE CODES

☐ NP Comprehensive Eye Exam $149 92004	☐ EP Comprehensive Eye Exam $125 92014	☐ Closure of Punctum (by plug) $275 68761	☐ Gonioscopy $49 92020
☐ NP Intermediate $85 92002	☐ EP Intermediate $89 92012	☐ Dilation of Lacrimal Punctum $250 68801	☐ Visual Field $109 92083
☐ NP Simple $55 99201	☐ EP Simple $45 99211	☐ Probing of Nasolacrimal Duct $350 68810	☐ Fundus Photography $89 OD OS 92250
☐ NP Expanded $90 99202	☐ EP Expanded $60 99212	☐ Lacrimal Plug (Product) $75 A4263 (99070)	☐ External Photography $79 OD OS 92285
☐ NP Detailed $125 99203	☐ EP Detailed $75 99213	☐ After Hour ER $150 99050	☐ OCT $79 92134
☐ NP Comprehensive/Moderate $200 99204	☐ EP Comprehensive/Moderate $123 99214	☐ Sunday / Holiday ER $150 99054	☐ FB Removal - Embedded Conj. $150 65210
☐ NP CL Evaluation I/$29 II /$49 III/$69 IV / $89 V/ $109 92310	☐ EP CL Evaluation I/$29 II /$49 III/$69 IV / $89 V/ $109 92310	☐ Post-Op Cataract $150 66984.55	☐ FB Removal - Cornea $200 65220
☐ Therapeutic Lens $100 99071	☐ Extended Ophthalmoscopy Initial OD/OS $75 92225	☐ Post- Op YAG $75 66821.55	☐ Lashes Epilation $85 67820
☐ Refraction $50 92015	☐ Extended Ophthalmoscopy Subsequent OD/OS $75 92226	☐ No Charge $0 90008	☐ Other

DIAGNOSIS CODES

☐ Accommodative Insufficient	H52.4	☐ Glaucoma Suspect	H40.009	☐ Papilledema	H47.10
☐ Amblyopia	H53.009	☐ Glaucoma Open Ang	H40.11X	☐ Pinguecula	H11.159
☐ Aphakia	H27.00	☐ Headache	R51	☐ Presbyopia	H52.4
☐ Asteroid Hyalosis	H43.23	☐ Headache Migraine	G43.809	☐ Pseudophakia	Z96.1
☐ Astigmatism	H52.223	☐ Herpes Simplex	B00.50	☐ Pterygium	H11.009
☐ Blepharitis	H01.009	☐ Herpes Zoster	B02.33	☐ Ptosis	H02.409
☐ Cataract-Non-Senile	H26.009	☐ Hordeolum Ext	H00.019	☐ Retinal Detachment	H33.009
☐ Cataract-Senile	H25.9	☐ Hordeolum Int	H00.029	☐ Retinal Hemorrhage	H35.60
☐ Cen Serous Retinopathy	H35.719	☐ Hyperopia	H52.03	☐ Retinal Ischemia	H35.82
☐ Chalazion	H00.19	☐ Hypertensive Retin	H35.039	☐ Retinal Neovascular	H33.009
☐ Conjunctivitis	H10.9	☐ Iritis	H20.00	☐ Retinal Scar	H31.00
☐ Convergence Insufficient	H51.11	☐ Keratitis Exposure	H16.219	☐ Retinal Tear	H33.23
☐ Corneal Dystrophy	H18.50	☐ Keratitis Superficial	H16.109	☐ Retinitis Pigmentosa	H35.52
☐ Corneal Edema	H18.20	☐ Keratitis Unspecified	H16.119	☐ Scleritis	H15.009
☐ Corneal Foreign Body	T15.0 123	☐ Keratoconus	H18.603	☐ Serous RPE Detachment	H31.429
☐ Corneal Scar	H17.9	☐ Macular/Retinal Edema	H35.81	☐ Staphyloma, Posterior	H18.729
☐ Corneal Ulcer	H16.9	☐ Macular Degeneration	H35.30	☐ Strabismus	HS0.60
☐ Diabetes Mellitus w/o Complication	E11.9	☐ Macular Hole	H35.34	☐ Subluxation of lens	H27.119
☐ Diabetic Retin Backgrd	E11.39	☐ Macular Puckering	H35.37	☐ Trichiasis	H02.059
☐ Diabetic Retin Prolif	E11.359	☐ Macular Wrinkle	H35.37	☐ Visual Field Defect	H53.40
☐ Diplopia	H53.2	☐ Myopia	H52.13	☐ Vitreous Floaters	H43.39
☐ Dry Eye Syndrome	H04.129	☐ Normal Eye Exam	Z01.00	☐ Vitreous Hemorrhage	H43.13
☐ Ectropion	H02.109	☐ Nasolac.Duct Obstruction	H04.539	☐ Vitreous Detachment	H43.40
☐ Entropion	H02.009	☐ Nystagmus	H55.0	☐ Vitreous Prolapse	H43.04
☐ Episcleritis Unspec	H15.109	☐ Ocular Hypertension	H40.059		
☐ Glaucoma Low Tension	H40.12	☐ Optic Atrophy	H47.20		
☐ Glaucoma Narrow Angle	H40.009	☐ Optic Neuritis	H46.9		

I authorize the release of any medical information necessary to process this claim.
I also request, authorize, and assign payment of all applicable benefits to the provider of these services, and agree to pay for any amounts not covered.

_____ ____ / ____ / ____
Patient or Legal Guardian's Signature *Date*

Exam/ CL Fit _____
Materials _____
Total Fees _____
Payment _____
Balance _____
Next Appointment _____

SB1SW 08/21