

**Ambulatory Surgical Center
IMPLANT ITEMIZATION FORM**

ASCs may complete this form in order to be reimbursed under the exception payment provision. This provision requires ASCs to submit implant billings on a properly completed UB-04 claim form **and** on this Implant Itemization Form. Clearly identify the implants subject to reimbursement and the manufacturer’s invoice, indicating the cost of the item charged to the ASC to support the claim, on this form. The item and units matching the implant must be included in the detail itemization. Implant claims not submitted in accordance with these requirements **shall not be entitled to reimbursement** under the exception payment provision.

Date Completed _____

ASC Name _____

ASC Tax ID# _____

Member Name _____

Member ID# _____

Member Account # _____

Date of Service _____

Information Per UB Claim Form						Per Manufacturer's Invoice
Line # on Claim	CPT/HCPCS Code	Revenue Code	CPT/HCPCS Description	Units of Service	Billed Amount	Name of Manufacturer