ANDREW DISIMONE WIGS

855 Lexington Ave 2nd Floor
New York, NY 10065
(212) 249-8866

HAIRPLACE NYC
EVERYTHING HAIR
home of AndrewDiSimoneWigs.com

How To: File an Insurance Claim for a Medical Hair Prosthesis

Step 1. Get Pre-Approved: Prior to purchasing a medical wig, ask your insurance provider if they cover this expense. Ask them via email so you have a record of their response.

Step 2. Get Coverage Amount: Ask your salon to provide you with an estimate for a human hair medical hair prothesis. Submit the estimate to your insurance provider to see how much they will cover. If they only cover synthetic hair, ask the salon for a synthetic wig estimate and re-submit it to your insurance provider for approval. See our wig estimates (pages 2 and 3).

Step 3. Find a Wig Provider: If your insurance company requires an 'in-network provider', ask them to make an exception and honor an 'out-of-network provider". That way, you can use a local provider of your choice, making it more convenient to purchase a wig and get it serviced. To use our salon, ask your insurance provider to lookup Federal Tax ID: #13-3925124 (we will be in their system).

Step 4. Schedule Wig Consultation: Once your insurance provider approves you for a wig, you can schedule a consultation at your salon. We offer complimentary, one-hour consultations Monday to Saturday between 11:00am and 6:00pm, Sundays upon request. We are located on the second floor, no elevator. Additional consultations are $75 per hour.

Step 5. Submit Claim: After you purchase a wig, ask your insurance provider for their Medical Claim Form #1500, or download it from their website. Fill out the form and submit the claim to your insurance provider to get reimbursed.

A list of things you'll need:

1. **Claim Form #1500**: Ask your insurance provider for this. See sample form (page 4).
2. **Our Federal Tax ID**: #13-3925124.
3. **Our National Provider ID**: 1992002042.
4. **Our License #**: 045279.
5. **Procedure Code**: The most commonly used codes are A9282 (synthetic wig) and L8499 (human hair wig).
6. **Prescription**: Ensure your doctor writes the Rx for a 'Medical Hair Prosthesis' or 'Cranial Prosthesis" (NOT a wig), and make sure they include your diagnosis code.
7. **Receipt for Wig**: Must indicate you paid in full and show details (i.e., type of wig, total, tax, purchase date, company, address).

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Below is an estimate for a human hair wig:

Invoice

HairPlaceNYC
855 Lexington Ave. 2nd Floor
New York, NY 10065
(212) 249-8866
hairplacenyc.com

Order #: **100849221685**
Date: Sep 21, 2023 9:09 am
Customer: Wig Estimate

Order Items

Dyana 16" LF Euro (HPBL3) ($5,200.00) Quantity: 1	**$5,200.00**
Sub Total:	**$5,200.00**
Sales Tax (varies):	$461.50
Total Tax:	**$461.50**
Total:	**$5,661.50**

Procedure Codes for Wigs :
Human (L8499) & Synthetic (A9282)
Vendor Tax ID # 13-3925124-NPI # 1992002042

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How To: File an Insurance Claim for a Medical Hair Prosthesis

Below is an estimate for a synthetic hair wig:

Invoice

HairPlaceNYC
855 Lexington Ave. 2nd Floor
New York, NY 10065
(212) 249-8866
hairplacenyc.com

Order #: **100849221685**
Date: Sep 21, 2023 9:10 am
Customer: Wig Estimate

Order Items

Limited 14 LF HR Synthetic Hair Medical Hair Prosthesis (HPRL2/4) ($1,450.00) Quantity: 1	**$1,450.00**
Sub Total:	**$1,450.00**
Sales Tax (varies):	$128.69
Total Tax:	**$128.69**
Total:	**$1,578.69**

Procedure Codes for Wigs :
Human (L8499) & Synthetic (A9282)
Vendor Tax ID # 13-3925124-NPI # 1992002042

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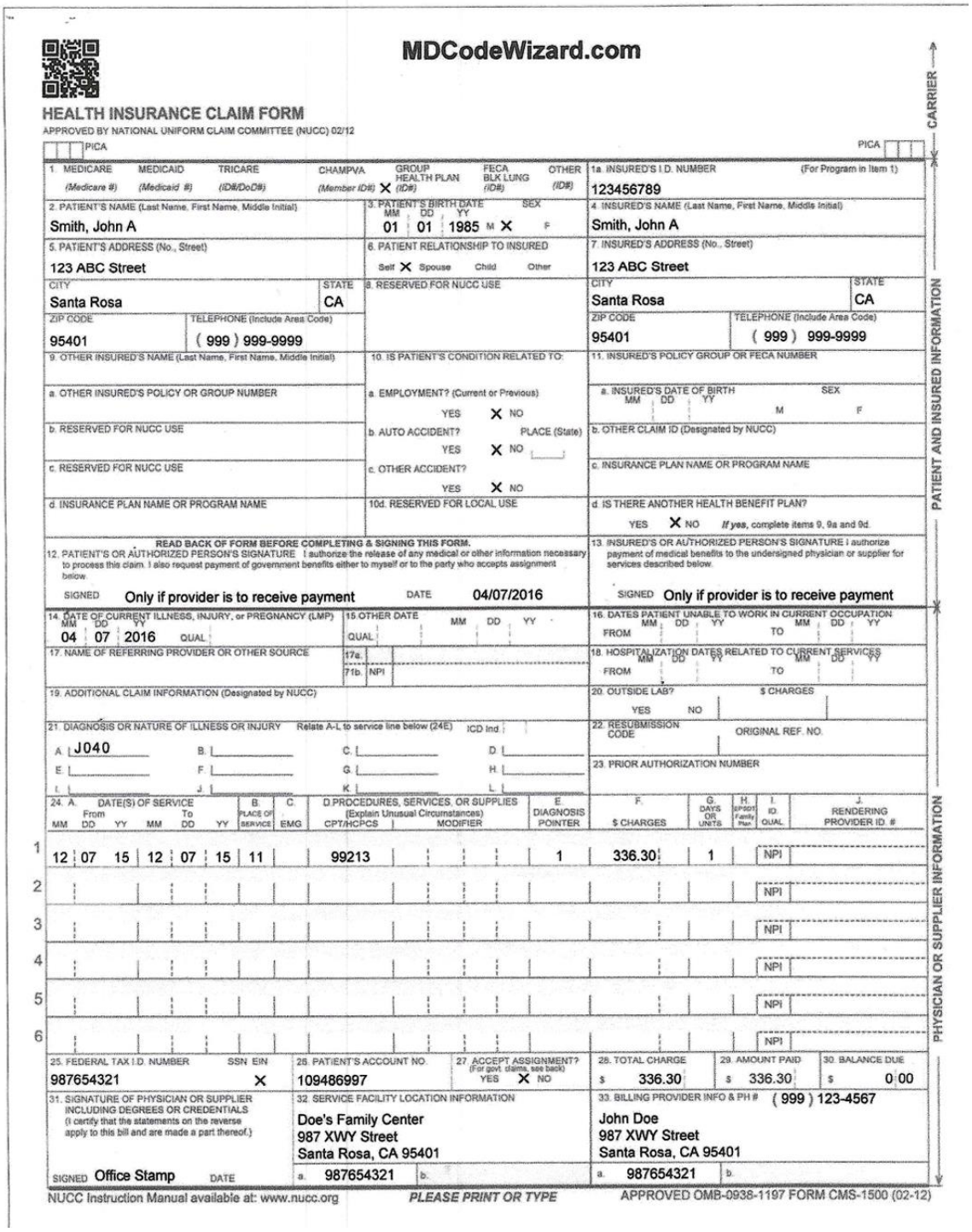
How To: File an Insurance Claim for a Medical Hair Prosthesis

Below is a sample insurance claim form:



MDCodeWizard.com

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#) X / FECA BLK LUNG (ID#) / OTHER (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1985 SEX M X F		4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, John A
5. PATIENT'S ADDRESS (No., Street): 123 ABC Street	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other		7. INSURED'S ADDRESS (No., Street): 123 ABC Street
CITY: Santa Rosa / STATE: CA	8. RESERVED FOR NUCC USE		CITY: Santa Rosa / STATE: CA
ZIP CODE: 95401 / TELEPHONE (Include Area Code): (999) 999-9999			ZIP CODE: 95401 / TELEPHONE (Include Area Code): (999) 999-9999
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
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		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 Only if provider is to receive payment DATE 04/07/2016			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 Only if provider is to receive payment
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 07 2016 QUAL.	15. OTHER DATE MM DD YY QUAL.		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI		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 J040 B 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 12 07 15	12 07 15	11		99213		1	336.30	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 987654321 X	26. PATIENT'S ACCOUNT NO.: 109486997	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 336.30	29. AMOUNT PAID: $ 336.30	30. BALANCE DUE: $ 0 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.) SIGNED Office Stamp DATE	32. SERVICE FACILITY LOCATION INFORMATION: Doe's Family Center, 987 XWY Street, Santa Rosa, CA 95401 a. 987654321 b.		33. BILLING PROVIDER INFO & PH # (999) 123-4567: John Doe, 987 XWY Street, Santa Rosa, CA 95401 a. 987654321 b.		

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — *PLEASE PRINT OR TYPE* — APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)