

Anaesthesia Billing Form for WorkSafeNB Claimants

WorkSafeNB internal use only - Doc. Code AD

| Claimant: | | Claim #: |
|---------------|-------------------------------|--------------------------|
| | | Date of accident: |
| Diagnosis: | | Part of the body: |
| Physician: | | Payee #: |
| Surgery date: | Anaesthesia start time: | Surgery authorization #: |
| | Anaesthesia duration (hours): | Minutes: |

Note: WorkSafeNB uses the *Medicare Manual* to guide its payment for surgical procedures.

- 1. First five procedure rows captures primary surgery basic units, basic time units and modifiers.
- 2. Enter unit rate and fee in each line item; and sum the units and fees in "Primary Total Units" row.
- 3. If Patient Controlled Analgesia is applicable, enter # days, unit rate and fee in procedure 8 and 9.
- 4. Use procedure rows 6-7 for additional procedures billed at anaesthesia unit rate and 10-12 for additional procedures billed at the general rate.
- 5. Filing bonus is calculated automatically by our system. Please use the base unit rate for > 5 days in the unit rate column.

| Procedure # | Procedure | Medicare Code | Medicare Units | PCA days | Unit Rate | Fee | |
|-------------------------------------|---|-------------------------------|--------------------|---------------------------------|---------------------------------|---------------|--|
| 1 Р | Primary Basic Units | | | | | | |
| 2 P | Primary Time Units | | | | | | |
| 3 M | forbid Obesity | □ BMI > 40 < 51 □ BMI > 50 | | | | | |
| 4 P | Primary Modifier #1 | | | | | | |
| 5 P | rimary Modifier #2 | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| Р | Primary Total Units | | | | | | |
| 8 ^{Ir} | nitiation Patient Controlled Analgesia | 841 | 62 | | | | |
| 9 Mai | intenance Patient Controlled Analgesia | 842 | 12 | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |
| Second anaesthetist required \Box | | | | Total Adjusted for after-hours: | | | |
| ustification attached | | | | Adjust | ed for second | anaesthetist: | |
| | e or bilateral procedures billing forms for each a | | eparate times and | | nt submitted: te anaesthesia | s, | |
| Comments: | | | | | | | |
| | Physician Offic | e Stamp | | or | | | |
| | , | | | Physician Ad | dress: | | |
| | | | | City, Town, V | | | |
| | | | | Postal Code: | - | | |
| | | | | Phone: | | | |
| declare that this is | a correct statement of s | services rendered b | y me for which I I | | | | |
| | | | - | | | | |
| signature: | | | | Date: | | | |

This form should be faxed to WorkSafeNB at 1 888 629-4722.