**Tuberculosis Program**
**Billing Description**

| Vendor | to | Billing Dates |
|---|---|---|

| *DIRECTLY-OBSERVED THERAPY* | | | | | |
|---|---|---|---|---|---|
| **Patient initials or TBdb #** | **Office visits @ $12.50** | | **Field visits @ $25.00** | | **Total $** |
| | **#** | **$ amount** | **#** | **$ amount** | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | Total | $ |

| *DIAGNOSTIC TESTING* | | | | | | |
|---|---|---|---|---|---|---|
| **Description of service (CPT Code)** | **Total number** | | **Reimbursed @** | | | **Total $ amount** |
| | | | **Medicaid rate** | **Other rate**** | | |
| PA chest x-ray* (71020) | | x | $35.00 | | = | |
| LAT chest x-ray* (71020) | | x | $35.00 | | = | |
| Apical lordatic chest x-ray (71021) | | x | $13.44 | | = | |
| Hepatic function panel (80076) | | x | $10.73 | | = | |
| Blood count; manual differential WBC includes RBC morphology & platelet est. (85007) | | x | $4.52 | | = | |
| Blood count; automated differential WBC includes RBC morphology & platelet est. (85025) | | x | $9.28 | | = | |
| Office Visit (please describe visit type) | | x | | | = | |
| Other (please describe and list CPT code) | | x | | | = | |

*Medicaid reimbursement rates for PA and LAT chest x-rays are actually $20.16. CDPHE will continue to reimburse at $35.00

**Justification of reimbursement amount is required if not requesting Medicaid reimbursement rate.

Note: Medicaid rates as of 08/03/05