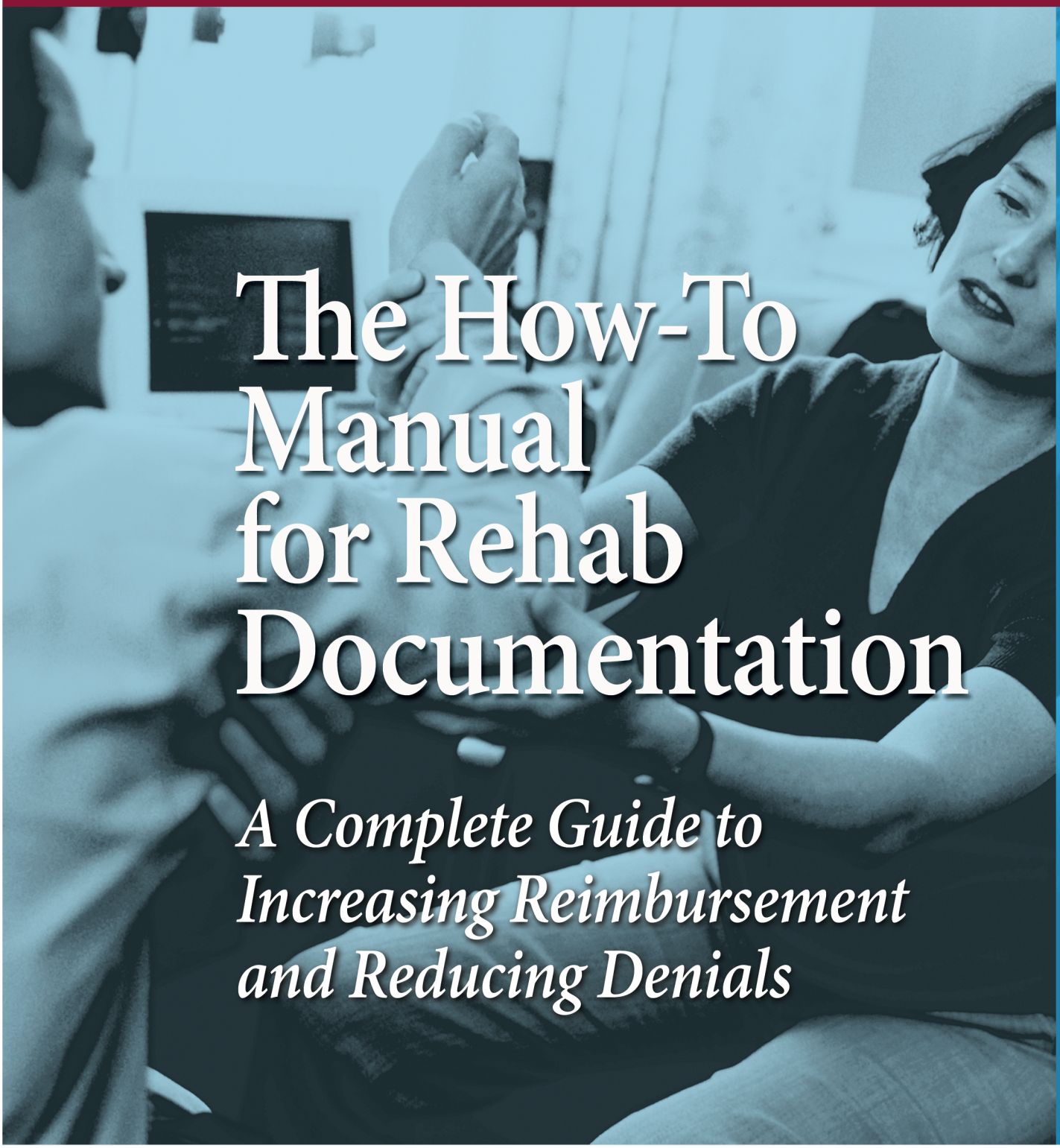
THIRD EDITION



The How-To Manual for Rehab Documentation

A Complete Guide to Increasing Reimbursement and Reducing Denials

Rick Gawenda, PT

THIRD EDITION

The How-To Manual for Rehab Documentation

A Complete Guide to Increasing Reimbursement and Reducing Denials

Rick Gawenda, PT

HCPro

The How-To Manual for Rehab Documentation: A Complete Guide to Increasing Reimbursement and Reducing Denials, Third Edition, is published by HCPro, Inc.

ISBN: 978-1-60146-323-4

Rick Gawenda, PT, Author
Kate Brewer, PT, MBA, GCS, Reviewer
Adrienne Trivers, Managing Editor
Elizabeth Petersen, Executive Editor
Emily Sheahan, Group Publisher
Janell Lukac, Graphic Artist
Genevieve d'Entremont, Copyeditor
Liza Banks, Proofreader
Matt Sharpe, Production Supervisor
Susan Darbyshire, Art Director
Jean St. Pierre, Director of Operations

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions. Arrangements can be made for quantity discounts. For more information, contact:

HCPro, Inc.
P.O. Box 1168
Marblehead, MA 01945
Telephone: 800/650-6787 or 781/639-1872
Fax: 781/639-2982
E-mail: *customerservice@hcpro.com*

Visit HCPro at its World Wide Web sites:
www.hcpro.com and *www.hcmarketplace.com*

4/2009
21658

Contents

Figure List

Additional Forms

Acknowledgments

There are many people whom I would like to thank for contributing to my ability to write this book about rehab documentation.

First and foremost are my wife, Rhonda, and daughters, Delaney, Lauren, Ashleigh, and Rebecca. Without their love, patience, and understanding, I would not be where I am today. The toughest job in the world is raising children, and without my wife's dedication and commitment to our children, and her understanding of my professional ambitions, I would not be able to do what I do and achieve what I have been able to achieve professionally.

I would also like to thank my mother, Jean Gawenda. After my father passed away when I was only nine years old, my mother returned to school and earned a degree so she could get a job and take care of my sister and me. My mother showed me at an early age what it takes to be successful and to overcome the challenges and obstacles that may occur in life.

Additionally, I would like to acknowledge Tim Weise, MA, CCC-SLP, director of physical medicine and rehab at Garden City (MI) Hospital, for his mentorship throughout my career and for giving me my start in management.

Lastly, I would like to thank all of the individuals who have provided me with invaluable knowledge and mentoring during the course of my professional career.

About the Author

Rick Gawenda, PT, graduated in 1991 with a bachelor's of science in physical therapy from Wayne State University in Detroit. He is currently the director of physical medicine and rehabilitation at Detroit Receiving Hospital and the owner of Gawenda Seminars. He has provided valuable education and consulting to hospitals, rehabilitation agencies, private practices, and his peers in the areas of CPT and ICD-9 coding, billing, documentation, reimbursement as it pertains to outpatient therapy services, and the appeals process for Medicare-denied claims. His Web site, *www.gawendaseminars.com*, is a valuable source of information on rehabilitation rules and regulations, coding, documentation, and reimbursement.

Gawenda is the current president of the Section on Health Policy & Administration of the American Physical Therapy Association (APTA), as well as president of the Michigan Association of Medical Rehabilitation Program Administrators. He is on the editorial advisory board for **Advance for Directors in Rehabilitation** and **Briefings on Outpatient Rehab Reimbursement and Regulations**. He is the consulting editor for **Eli's Rehab Report**. He is a member of the APTA, Michigan Physical Therapy Association (MPTA), and MPTA Insurance Relations Committee. He serves as the liaison between the MPTA and National Government Services, which is the Medicare fiscal intermediary for the State of Michigan. He is also the author of *Coding and Billing for Outpatient Rehab Made Easy: Proper Use of CPT Codes, ICD-9 Codes, and Modifiers*.

CHAPTER 1

The Role of the Registration Staff

CHAPTER 1

The Role of the Registration Staff

Registration Basics

When you focus on preventing or reversing denials due to billing errors, documentation deficiencies, or services not considered reasonable and necessary, the tendency is to overlook another type of denial that is easily prevented. It has nothing to do with what you document or bill for, requirements for medical necessity, or physician referrals. Instead, it all begins with the preregistration process.

The preregistration process begins when clerical staff interview patients prior to examination, evaluation, and treatment in your outpatient facility. Make your clerical staff responsible for obtaining the necessary demographic and insurance information to verify a patient's therapy benefit coverage. If this information is not obtained, obtained incorrectly, or not verified by the clerical staff, therapy services may ultimately be denied—even if the documentation is adequate and all other requirements are met.

The preregistration interview may take place in person, over the telephone, or via fax from a physician's office. It may be conducted with patients, their spouses, case managers, physician offices, or other individuals associated with the patients. Whatever method is used, the information must be collected by clerical staff prior to your examination and treatment of the patient. This enables you to efficiently and effectively bill the payer for the services provided.

Make sure clerical staff know what information you need. Demographic information should include, but may not be limited to:

- Complete legal name
- Home address, including city, state, and zip code

- Telephone number
- Marital status
- Social Security number
- Birth date
- Medicare number

In addition, obtain the referring physician's name and phone number, along with the patient's emergency contact's name and phone number.

A preprinted rehabilitation therapy registration form will help ensure that your registration staff remember to collect critical information, if you are not entering the information directly into your billing/registration system. Figures 1.1 and 1.2 are filled-in versions of sample rehabilitation therapy registration forms. The registration form on the CD-ROM that accompanies this book can be printed and filled out by staff at your facility.

Insurance information

After collecting demographic information, staff should obtain details regarding patients' insurance. Remember, patients may have more than one insurance plan, so ask for information from all payers.

Payer information should include, but may not be limited to:

- Insurance carrier
- Insurance billing address
- Contract number
- Group number, if applicable
- The name on the insurance card and any phone number on the back of the card to call and verify therapy benefit coverage
- Medicare number and supplemental or secondary insurance info

FIGURE 1.1 | REHABILITATION THERAPY REGISTRATION FORM (1)

Sample 1

Registrar *TS* Patient Has RX *Yes* Needs Ref *No* Date *8/24/08*

Patient Name *John Jones* Sex *M* M. Status *M* DOB *6/02/60*

Address *123 Honeycutt* Phone(s) *(555) 555-5555*

City *Detroit* State *MI* Zip *48201* S.S.# *123456789A*

Patient's Employer *Ford Motor Company* Phone# _____

Address _____

Emergency Contact *Debbie Jones* Relationship *Wife* Phone# *Same*

Physician *Dr. Paul Smith* Phone *(555) 123-4567* Fax *(555) 123-4568*

Diagnosis *Fx'd pelvis; Fx'd right ankle; Fx'd right humerus* ICD-9 Code _____

Insurance #1 *BCBS* Contract# *XYZ123456789* Group# *12000*

Address *123 Blue Cross Lane, Detroit, MI 48201* Phone# *1-800-555-5555*

Contact Person _____ Benefit Coverage *60 visits per Dx per year. Covered in full.*

Insurance #2 *Citizens Auto* Claim# *12312300* Group# _____

Contact Person *Julie Jones* Benefit Coverage *BCBS Primary, Pt has coordination of benefits*

Address *1234 Citizen Dr., Plymouth, MI 48170* Phone# *1-866-555-5555*

Auto Accident: Yes *X* No _____ Workers Compensation: Yes _____ No *X*

Injury Date *8/18/08* Claim# *024681* Benefit Coverage _____

Contact Person *Julie Jones* Phone# *1-866-555-5555*

Insurance Co. *Citizens* Address *1234 Citizen Drive, Plymouth, MI 48170*

Policy Holder (If different from Pt) _____ SS# _____ DOB _____

Misc. _____

Appt Scheduled On *8/24/08* Appt Date *8/26/08* Time *PT 9:00 AM/ OT 10:00 AM*

Therapist *JM, ES* PT *X* OT *X*

Comments: *Bill BCBS first, Citizens is secondary*

Are you currently receiving home nursing and/or home therapy? No *X* Yes _____

If yes, please specify what type: _____

FIGURE 1.2 | REHABILITATION THERAPY REGISTRATION FORM (2)

Sample 2

Registrar LM Patient Has RX Yes Needs Ref Yes Date 5/03/08

Patient Name Joann Smith Sex F M. Status M DOB 3/05/33

Address 1234 Connicut Phone(s) (555) 555-5555

City Detroit State MI Zip 48201 S.S.# 123456789A

Patient's Employer Retired Phone# _____

Address _____

Emergency Contact Laura Doe Relationship Daughter Phone# (555) 556-5555 (cell)

Physician Dr. Dave Brown Phone (555) 123-4567 Fax (555) 123-4568

Diagnosis Cervical Radiculitis ICD-9 Code 7220

Insurance #1 Medicare Contract# XYZ123456789D Group# _____

Address _____ Phone# _____

Contact Person _____ Benefit Coverage _____

Insurance #2 BCBS Contract# XYZ123456789 Group# 12345

Contact Person _____ Benefit Coverage 10% co-pay

Address _____ Phone# 1-800-555-5555

Auto Accident: Yes ____ No X Workers Compensation: Yes ____ No X

Injury Date _____ Claim# _____ Benefit Coverage _____

Contact Person _____ Phone# _____

Insurance Co. _____ Address _____

Policy Holder (If different from Pt) _____ SS# _____ DOB _____

Misc. _____

Appt Scheduled On 5/03/08 Appt Date 5/05/08 Time 10:00 AM

Therapist MJ PT X OT _____

Comments: _____

Are you currently receiving home nursing and/or home therapy? No X Yes _____

If yes, please specify what type: _____

- The name of the patient's employer (verify whether the insurance coverage is through the patient's employer or his or her spouse's; if the insurance is through the patient's spouse's employer, obtain the spouse's Social Security number)

- Any pertinent information affecting payment, such as an attorney's letter of protestation or capitated managed care arrangements

Physician referrals

Ask patients whether they need a referral for therapy services. Know your state direct access laws. If one is required, clerical staff must obtain the primary care physician's (PCP's) name, phone number, and fax number. A referral, as used in this context, is different from a physician's prescription or order and is usually required by managed care insurance carriers.

Patients' PCPs must authorize the number of therapy treatments they will allow, along with the start date, to validate the referral. Some PCPs may also document the end date. Depending on your facility, clerical staff should instruct patients to obtain the referral once an evaluation has been scheduled or to contact their physician's office to obtain the referral independently.

Regardless of the method used, your facility must have referrals prior to evaluation and treatment, or it risks denial. Become familiar with the requirements of each insurance plan, as they differ, and some plans may not require a referral.

Additional insurance questions

After gathering general information and discussing referrals, your clerical staff should ask every patient the following two questions:

1. Is your reason for requiring therapy services related to a work injury or automobile accident?

2. Are you receiving any type of home healthcare services? This includes nursing care, the services of a nursing aide, physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services, regardless of the frequency of visits.

If patients answer yes to either question, ask for additional information to assist in determining the primary insurance and whether they are covered to attend outpatient therapy.

Home health services

If the patient answers yes to the home healthcare question, clerical staff should ask the following additional questions:

- When is the home health agency (HHA) discharging you?
- What home health services are you receiving?
- How often does the HHA come to your home?

These questions will assist clerical staff in determining whether patients can attend outpatient therapy at your facility and whether the facility is eligible for reimbursement by Medicare.

Questions about home health services are important to ask of all patients but especially Medicare patients. Relevant services include, but are not limited to, skilled nursing, home health aide assistance, and PT, OT, and SLP services.

The frequency of these home health visits could range from five times a week to once a month. Remember that for home health services provided to Medicare patients, if the case is still open by the HHA, outpatient therapy services will not be reimbursed if the services overlap, because the home health prospective payment system (PPS) includes therapy services if patients are under an open HHA plan of care (POC).

TIP

Home Health Therapy Services

An HHA opens a case on January 5, 2009, and closes the case on February 26, 2009. During this time, the patient attended outpatient therapy services at a local facility from February 17 until March 15, 2009. The therapy services provided between February 17 and February 26 are automatically denied because the patient was under a home health plan of care.

If you know that the Medicare patients are under an open HHA POC, you have two options:

1. Inform the patient that because they are currently receiving home healthcare services, the therapy services must be provided by the HHA.

2. Contact the HHA and develop a contract that lists the services to be provided by the outpatient facility and the payment amount required by the HHA to the outpatient facility for those services. Establish the price for the outpatient therapy services to the HHA—typically 100% of the Medicare Physician Fee Schedule for the appropriate current procedural terminology (CPT) code billed. The HHA has the right to accept or reject this proposed arrangement.

If the outpatient facility provides therapy services to a Medicare patient without prior approval of the HHA, the HHA is under no obligation to reimburse for those services. Medicare also will not reimburse the facility because the patient was under a HHA POC, and therapy services were included in the home health PPS, as mentioned earlier. For other third-party payers, check with the applicable insurance carriers to determine whether patients can receive outpatient therapy services while simultaneously receiving nontherapy home health services.

To check for open HHA claims, use the Medicare common working file (CWF). But be warned that this may not be completely accurate, because some HHAs may not submit their claims in a timely manner. It is possible for a provider to check the CWF, see no open claim at that time, begin therapy services on an outpatient basis, and then discover later that the patient was receiving home healthcare services simultaneously.

It is also possible that you could be reimbursed for the therapy services provided to a Medicare beneficiary but later have the money taken back by the Medicare contractor because a home health claim was submitted that overlapped with the dates of your outpatient therapy services.

Work injuries

For work injuries requiring therapy services, have your clerical staff obtain the patient's insurance company's contact name and telephone number, as well as the claim number for the incident.

Staff then must call and verify that the patient has an open claim, determine how many visits the case manager is authorizing, and obtain the address to mail the claim for the therapy services to be provided. Following these guidelines will help you receive a timely reimbursement.

Automobile injuries

The above protocol is similar for injuries requiring therapy services due to an automobile accident: Staff must obtain the insurance company's contact name and phone number, as well as the claim number. They then must contact the automobile insurance carrier to determine whether the automobile insurance or the patient's medical insurance is primary. This will be the insurance to which the provider first submits the claim for payment. If the patient has no medical insurance and his or her automobile insurance is current, then the automobile insurance is primary and will most likely be responsible for the claim. Exceptions could exist if the patient was driving while intoxicated, driving while impaired by illegal drugs, eluding police, etc. If the patient has both current medical and automobile insurance coverage, the automobile insurance will inform the provider if the patient has coordination of benefits (COB).

Coordination of benefits

COBs are used when a patient has two or more insurance plans that provide coverage for the same allowable service and expense. They are designed to prevent the duplication of payment for the same service and limit the amount paid to no more than the actual amount incurred.

If the patient does have COBs, his or her medical insurance will be primary, and the automobile insurance will be secondary. If the patient does not have COBs, the automobile insurance will be primary, and the medical insurance will be the secondary payer.

Most automobile insurance policies have COBs because it makes the automobile insurance policy less expensive for the driver. Clerical staff must determine the primary payer when automobile insurance is involved to avoid a delay in submitting your claim to the correct carrier. This is especially true if the patient's medical insurance is primary and requires a PCP referral for therapy. If you assume the automobile insurance is primary without considering the medical insurance, you will not have obtained the required referral from the PCP, and the medical insurance won't reimburse you for the therapy services. Likewise, the automobile insurance may not cover the services as the secondary insurance. Submitting your claim to the correct insurance carrier the first time will improve the timeliness of your reimbursement.

Medicare as a secondary payer

If the patient is a Medicare beneficiary and has valid automobile insurance, Medicare is always the secondary payer. Before submitting the claim to Medicare, first submit it to the automobile insurance company for payment.

Medicare may be the primary payer if the beneficiary is:

- 65 years or older and does not work
- Disabled and covered by Medicare and COBRA
- 65 years or older, covered by a group health plan through an employer or a spouse's employer, and that employer has fewer than 20 employees

Medicare may be the secondary payer if the beneficiary:

- Is 65 years or older, covered by a group health plan through an employer or a spouse's employer, and that employer has 20 or more employees
- Has been in an accident where no-fault or liability insurance is involved
- Sustained a job-related injury or illness and is covered under workers' compensation
- Has Veterans Health Administration benefits

Medicare may make payment if the primary insurance does not pay for certain services that are covered benefits, such as under the following circumstances:

- The group health plan denies payment for services because the beneficiary is not covered by the health plan
- The no-fault or liability insurer does not pay or denies the medical bill
- Workers' compensation denies payment, as in situations where workers' compensation is not required to pay for a given medical condition
- The Federal Black Lung Program will not pay the bill

Medicare also may make conditional payments to the provider when the primary payer has not paid within 120 days of receiving the claim. Medicare does have the right to recover this payment if and when the primary payer does pay or if Medicare determines that another payer should have paid the claim.

Centers for Medicare & Medicaid Services (CMS) has developed an excellent eight-page fact sheet detailing situations when Medicare would be the primary payer and when they would be the secondary payer. It is called the "Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff" and can be accessed at *www.cms.hhs.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf*.

Benefit Verification

Once you've determined the patient's medical insurance is primary, clerical staff should call and verify therapy benefit coverage prior to the patient's initial visit, either over the telephone or Internet. Many insurance carriers now have an automated telephone system for verifying benefit coverage, in addition to speaking with a representative. When verifying coverage, your clerical staff should record the:

- Number of days or visits the coverage allows
- Deductible or copay amounts
- Effective date of coverage
- Name of the individual with whom the staff member spoke, if applicable

The following are examples of allowed coverage days or visits:

- **Sixty consecutive days per diagnosis per year.** Count the first day as the evaluation day, and count 60 days from that date, including Saturdays, Sundays, and holidays. Therapy services provided on day 61 and after are not covered for that diagnosis. Some insurance plans may begin counting the 60 consecutive days from the first date of treatment which may not be the same date as the evaluation date. For example, you evaluate a patient on January 5, 2009, but provide no treatment on that date. The patient then

returns on January 7, 2009 to begin treatment. The 60 consecutive days would start from January 7, 2009 and not January 5, 2009 in this example. It is important for your clerical staff to know when the 60 days begins.

- **Sixty visits per condition per year.** The beneficiary has 60 visits for the entire calendar year per condition and may combine therapy services for the same condition. For example, a beneficiary sustains a cerebrovascular accident (CVA) and receives PT, OT, and SLP services. The benefit coverage provided by the insurance plan is 60 visits per condition, so each visit to the PT, OT, and SLP count as one visit. Patients who attend all three disciplines three times per week use nine visits of their benefit maximum every week. In the above example, some insurance plans would say that was only three visits used since the patient had all three disciplines on one day, that would only count as one visit. It is important for your clerical staff to understand how the insurance company is counting a visit when a patient is receiving two or more disciplines of outpatient therapy services on the same day.

- **Sixty visits per discipline per condition per year.** This applies, for example, to beneficiaries who sustain CVAs and receive PT, OT, and SLP services. The benefit coverage provided by the insurance plan is 60 visits per condition per discipline. So if the treatment was medically necessary and patients continue to progress, they are covered for 60 visits each of PT, OT, and SLP services.

- **Twelve visits within 30 days.** This type of benefit coverage typically is seen with a managed care insurance carrier. In this example, the 12 visits would need to occur between those dates for the therapy services to be eligible for reimbursement.

When verifying insurance coverage and therapy benefits, the insurance carrier provides you with information called a "quote of benefits." It does not guarantee payment but does inform providers about the coverage and benefits of the insurance policy. However, documentation still must support the need for skilled therapy services, and it is the documentation of medical necessity that will determine whether a claim is reimbursed or denied. In some instances, particularly with workers' compensation or managed care, you will be provided with an initial authorization for a specified number of visits.

Develop a system

Create a way to inform therapists of patients' therapy benefits coverage so they don't use more visits than allowed or treat the patient beyond the permissible treatment period. A small form on a sticker that can be placed on the front of the patient's chart is one way to relay that information. It should list the insurance carrier, deductibles/copays, effective date of coverage, and number of visits allowed.

Figure 1.3 provides an example of an insurance sticker label you can use at your facility. Use the insurance label template on the accompanying CD-ROM to make customized labels for your facility.

FIGURE 1.3 | INSURANCE LABEL

INSURANCE: _____

BENEFIT COVERAGE: _____

AUTH#: _____

COPAY/DEDUCTIBLE DUE: $: _____

Preregistering

Now that all the necessary information has been collected, clerical staff can preregister the patient. This involves entering the demographic and insurance data into the computer system. To save time, preregistration should be completed prior to the patient's initial evaluation. When the patient arrives for the initial evaluation, clerical staff should only have to ask whether any information has changed or review the information already in the computer system.

On the day of the initial evaluation, clerical staff should make a copy of both the patient's insurance card and identification card (usually a driver's license) and ask him or her to sign any paperwork or forms required by your facility, such as an authorization to treat form or a Health Insurance Portability and Accountability Act of 1996 form.

Clerical staff should also explain the patient's benefit coverage, including any copayments and deductibles, and inform him or her that the benefit coverage information is only a quote of benefits and does not guarantee payment. Clerical staff can then review the information, make any changes, and complete the registration process to activate the patient in your system.

Additional training

The Centers for Medicare & Medicaid Services offers free educational training sessions on its Web site. To access this training, go to *www.cms.hhs.gov/MLNGenInfo*. Choose "Web Based Training (WBT) Modules," and then complete the courses appropriate to your setting.

The following nine courses may be of specific interest:

- Front Office Medicare
- Medicare Fraud and Abuse
- HIPAA
- Diagnosis Coding Using the ICD-9-CM
- CMS Form 1500
- Understanding the Remittance Advice for Institutional Providers
- Understanding the Remittance Advice for Professional Providers
- Uniform Billing (UB) -04
- World of Medicare

On completion of each course, print the transcript with your score and have it transferred to your employee file.

Also check with your Medicare Administrative Contractor, carrier, or fiscal intermediary to determine what trainings are offered in your state. Many Medicare contractors offer both online and workshop courses for therapists.

Having clerical staff who are well trained in insurance verification and COBs can significantly improve the timeliness of your facility's reimbursement. It can also decrease your chance of nonpayment due to a patient's lack of current insurance coverage or therapy coverage as part of his or her insurance plan. As you work to decrease the billing errors and denials occurring in your facility, don't overlook the registration process. Many times it's overlooked as a tool to increase reimbursement, but it can often be a source of unnecessary complications if you fail to streamline your information-gathering skills.

Resources

CMS, *Medicare Benefit Policy Manual,* Chapter 7—Home Health Services, Section 10.12, *www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf.*

CMS, *Medicare Claims Processing Manual*, Chapter 10—Home Health Agency Billing, Section 20.2.2 *www.cms.hhs.gov/manuals/downloads/clm104c10.pdf.*

CMS, *Medicare Secondary Payer (MSP) Manual,* Chapter 2—MSP Provisions, *www.cms.hhs.gov/manuals/downloads/msp105c02.pdf.*

CMS, *Medicare Learning Network (Medlearn) Publications*, "Medicare Secondary Payer Fact Sheet," *www.cms.hhs.gov/MLNProducts/downloads/MSP_Fact_Sheet.pdf.*

CMS, *MSP Manual,* Chapter 2—MSP Provider Billing Requirements, Section 10.3, *www.cms.hhs.gov/manuals/downloads/msp105c02.pdf.*

CMS, *MSP Manual,* Chapter 3—MSP Provider Billing Requirements, Section 30.2.1.1, *www.cms.hhs.gov/manuals/downloads/msp105c03.pdf.*

HCPro

Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit *www.hcmarketplace.com*. If you received a special offer or discount source code, please enter it below.

Title	Price	Order Code	Quantity	Total
				$

Your order is fully covered by a 30-day, money-back guarantee.

Shipping* (see information below)	$
Sales Tax** (see information below)	$
Grand Total	$

➲ **Enter your special Source Code here:**

Name

Title

Organization

Street Address

City State ZIP

Telephone Fax

E-mail Address

***Shipping Information**
Please include applicable shipping. For books under $100, add $10. For books over $100, add $18. For shipping to AK, HI, or PR, add $21.95.

****Tax Information**
Please include applicable sales tax. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.

State that taxes products only: AZ.

BILLING OPTIONS:

☐ Bill me ☐ Check enclosed (payable to HCPro, Inc.) ☐ Bill my facility with PO # _____

☐ Bill my (✓ one): ☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

Signature Account No. Exp. Date

(Required for authorization) (Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at *www.hcmarketplace.com*

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: *customerservice@hcpro.com*

 Code: EBKPDF