# How To File an Insurance Claim for a Wig

**Step 1: Confirm Coverage**: Before purchasing a wig, reach out to your insurance provider to confirm whether they cover a "medical hair prosthesis" (Note: this is different from a cosmetic wig). Be sure to ask via email so you have a written record of their response.

**Step 2: Get Pre-Approved**: Once you confirm coverage, follow these steps:

**Determine Coverage Amount**: To find out how much your insurance will cover, send an estimate for a wig to your provider. We recommend starting with an estimate for a human hair wig. You can use our pre-written estimates (pages 2-3) or contact our salon for a custom estimate.

**Clarify Type of Coverage**: Ask your insurance company if you need to use an in-network provider or if they offer out-of-network benefits.

| If they cover... | Your next step... |
|---|---|
| **In-network providers** | Ask if they have a list of in-network providers. Please note that they likely won't have local salons in their network. |
| **Out-of-network benefits** | Ask if they accept Hair Place Inc. (Federal Tax ID #13-3925124). If not, request an exception so you can buy and service a wig at our salon. Also, ask if going out-of-network results in reduced coverage and if full benefits can be provided, given they don't have a list of local in-network salons. |

**Step 3. File a Claim**: After getting approval, schedule a complimentary consultation to choose your wig. We are available Monday-Saturday from 11:00am to 6:00pm. Additional consultations are $75/hour. Your wig purchase includes: Initial cut/styling, wig kit (shampoo, conditioner, brush, stand, grip, net), complimentary wash and style lesson. Once purchased, you can file a claim with your insurance provider. Here's what you'll need:

| | |
|---|---|
| **Claim Form #1500** | Download from our website or insurance provider. See page 4 or instructions |
| **Federal Tax ID** | #13-3925124 |
| **National Provider ID** | 1992002042 |
| **License #** | 045279 |
| **Procedure Code** | A9282: Synthetic wig \| L8499: Human hair wig |
| **Doctor Prescription** | Rx for a 'Medical Hair Prosthesis' or 'Cranial Prosthesis'. MUST include diagnosis code |
| **Receipt for Wig** | A receipt showing you paid in full |

**Download instructions, estimates and claim form**
**www.hairplacenyc.com/insurance**



HairPlaceNYC® • (212) 249-8866 • info@hairplacenyc.com
855 Lexington Ave. 2nd Floor @ 65th Street New York 10065

# How To File an Insurance Claim for a Wig

**Document**: 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)<br>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

# How To File an Insurance Claim for a Wig

**Document**: Estimate for a Synthetic 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

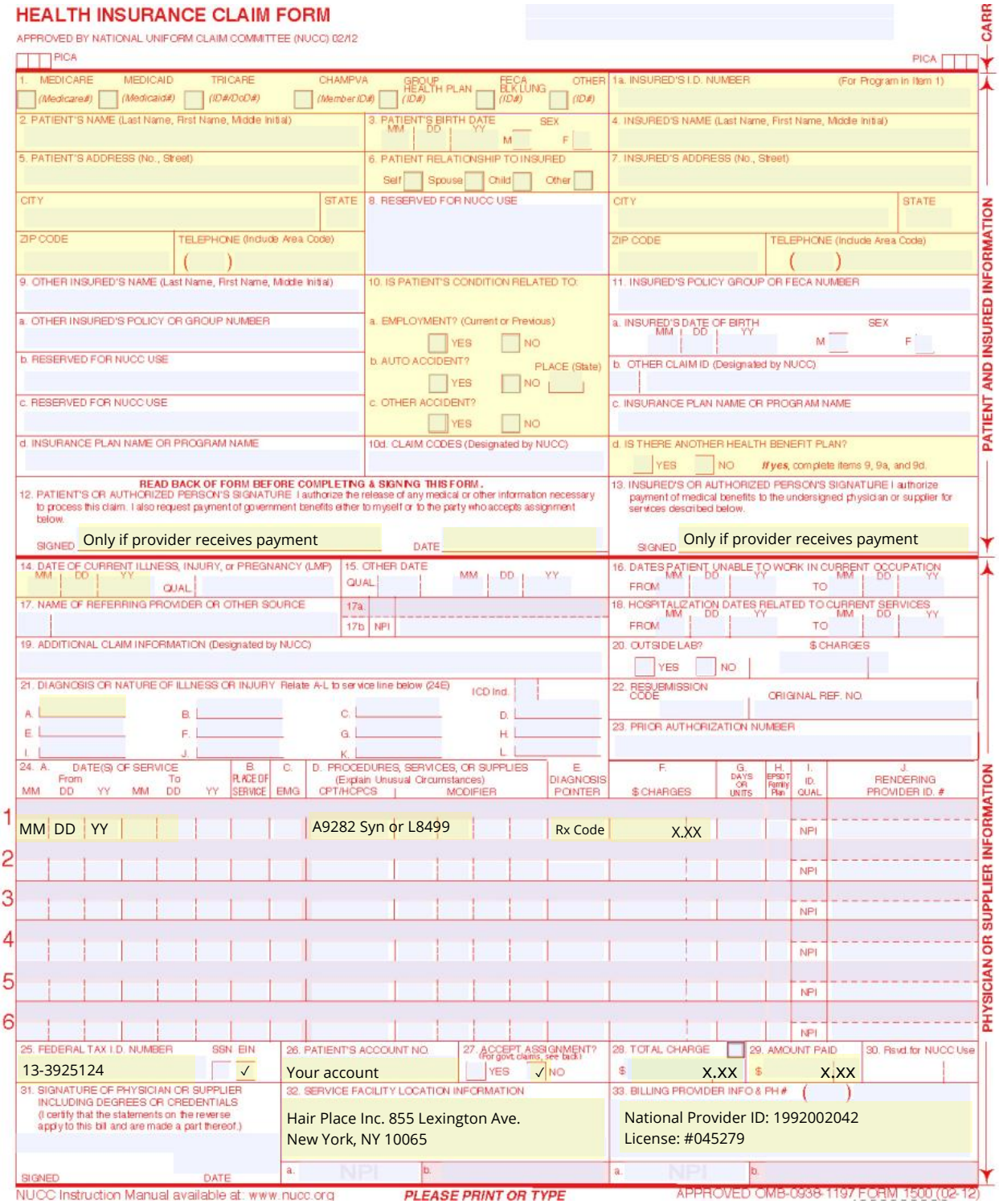
**Order Items**

| | |
|---|---|
| Limited 14 LF HR Synthetic Hair Medical Hair Prosthesis (HPRL2/4) ($1,450.00)<br>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

# How To File an Insurance Claim for a Wig

**Document**: Claim Form #1500 (fields in yellow are required)



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#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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 NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES 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 receives payment DATE

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 receives payment

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

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. 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 MM DD YY | | | | A9282 Syn or L8499 | | Rx Code | X.XX | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

13-3925124 ✓

26. PATIENT'S ACCOUNT NO.

Your account

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ✓ NO

28. TOTAL CHARGE $ X.XX

29. AMOUNT PAID $ X.XX

30. Rsvd for NUCC Use

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 DATE

32. SERVICE FACILITY LOCATION INFORMATION

Hair Place Inc. 855 Lexington Ave.
New York, NY 10065

a. NPI b.

33. BILLING PROVIDER INFO & PH #

National Provider ID: 1992002042
License: #045279

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARR

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



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