HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

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HFS USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)
2. PATIENT'S DATE OF BIRTH
AGE
3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.:
5. PATIENT'S SEX — MALE / FEMALE
6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS)
7. PATIENT RELATION TO INSURED — SELF / SPOUSE / CHILD / OTHER
8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.
9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER
10. WAS CONDITION RELATED TO
A. PATIENTS EMPLOYMENT — YES / NO
B. ACCIDENT — AUTO / OTHER
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
SIGNED
DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF — ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES / NO
CHECK HERE IF EMERGENCY
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY — FROM / THROUGH
DATES OF PARTIAL DISABILITY — FROM / THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
PROVIDER NUMBER
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES — ADMITTED / DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE — YES / NO — CHARGES:
23A. HEALTHY KIDS SERVICES — YES / NO
23B. FAMILY PLANNING — YES / NO
23C. STERILIZATION/ABORTION — YES / NO
23D. PRIOR AUTHORIZATION NUMBER
23E. T.O.S.*
23F DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S.*	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	MOD	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
1					PRIMARY			
2					SECONDARY			
3								
4								
5								
6								
7								

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL)
SIGNED
DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) — YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR PROVIDER NUMBER
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
32. YOUR PATIENT'S ACCOUNT NUMBER
33. YOUR PAYEE NUMBER
34. NUMBER OF SECTIONS
35. ORIGINAL DCN
36. ORIGINAL VOUCHER NUMBER

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i. e., items 3, 6, 7, 8, 9 and 11.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer the Medicare and CHAMPUS programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under Social Security or CHAMPUS law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

My Signature on the reverse side of this bill certifies that all entries on this claim are true, accurate and complete. I agree that payment received according to the State's Medical Assistance Program pricing limits will be accepted as payment in full and I will not accept additional payment from any person or persons.

I agree to keep and make available such records as are necessary to disclose fully the nature and extent of services provided and to furnish such information regarding any payments claimed as State and Federal officials may request. I understand that payment is made from State and Federal funds and that any false claims, statements, or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action.

Services were provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap in accordance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973.

PLACE OF SERVICE CODES

"For Medicaid submittal use the code in the column to the left of the description; for Medicare submittals use the code in the column to the right.

Place of Service Codes

1 – Inpatient Hospital – IH
2 – Outpatient Hospital – OH
3 – Doctor Office – O
4 – Patient's Home – H
5 – Day Care Facility (PSY) –
6 – Night Care Facility (PSY) –
7 – Nursing Home – NH
8 – Skilled Nursing Facility – SNF
9 – Ambulance –
0 – Other Locations – OL
A – Independent Laboratory – IL
B – Other Medical/Surgical Facility –
C – Residential Treatment Center – RTC
D – Specialized Treatment Facility – STF

Type of Service Codes

1 – Medical Care
2 – Surgery
3 – Consultation
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistance at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
G — Concurrent Care
M – Alternate Payment for Maintenance Dialysis
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery
C – Chiropractic Care
H – DME Rental
J – DME Purchase
K – DME Prescription
S – Co-Surgeon