

INVOICE/PAT ACCT NUMBER
SPECIAL PROGRAM CODE

HEALTH INSURANCE CLAIM

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. CLIENT NAME (LAST, FIRST, MIDDLE INITIAL)	2. CLIENT DATE OF BIRTH	3. MEDICAID ID NUMBER (CLIENT ID NUMBER)
4. CLIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. CLIENT SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. MEDICARE ID NUMBER (HIC OR SSN)
TELEPHONE NUMBER	7. CLIENT RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. <input type="checkbox"/> CLIENT IS COVERED BY EMPLOYER HEALTH PLAN AS EMPLOYEE OR DEPENDENT EMPLOYER NAME: _____
9. OTHER HEALTH INSURANCE COVERAGE — INSURANCE COMPANY NAME, ADDRESS, PLAN NAME, AND POLICY NUMBER(S)	10. WAS CONDITION RELATED TO: A. CLIENT EMPLOYMENT YES <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/> C. DATE OF ACCIDENT <input type="text"/>	POLICYHOLDER NAME: _____ GROUP: _____ 11. CHAMPUS SPONSORS SERVICE/SSN
TELEPHONE NUMBER	12. PREGNANCY <input type="checkbox"/> HMO <input type="checkbox"/> NURSING FACILITY <input type="checkbox"/>	

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF: <input type="text"/>	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR FIRST PREGNANCY (LMP)	14. MEDICARE DENIAL (ATTACH THE MEDICARE STANDARD PAPER REMITTANCE (SPR) IF EITHER BOX IS CHECKED) <input type="checkbox"/> BENEFITS EXHAUSTED <input type="checkbox"/> NON-COVERED SERVICES	14A. OTHER COVERAGE DENIED <input type="checkbox"/> NO <input type="checkbox"/> YES PAY/DENY DATE: _____
15. NAME OF SUPERVISING PHYSICIAN	PROVIDER NUMBER	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED: _____ DISCHARGED: _____	
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)	PROVIDER NUMBER	17A. CHECK BOX IF LABORATORY WORK WAS PERFORMED OUTSIDE THE PHYSICIANS OFFICE <input type="checkbox"/> YES	

18. ICD-9-CM	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. IN COLUMN F, RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE NUMBERS 1, 2, 3, OR 4	TRANSPORTATION CERTIFICATION ATTACHED <input type="checkbox"/> YES
1. _____	_____	DURABLE MEDICAL EQUIPMENT Line # Make Model Serial Number
2. _____	_____	
3. _____	_____	
4. _____	_____	PRIOR AUTHORIZATION #:

19A. DATE OF SERVICE FROM TO	B. PLACE OF SERVICE	C. PROCEDURE CODE (HCPCS)	MODIFIERS	D. RENDERING PROVIDER NUMBER	E. REFERRING PROVIDER NUMBER	F. DIAGNOSIS P S T	G. CHARGES	H. DAYS OR UNITS	I. COPAY	J. EMERG ENCY	K. FAMILY PLANNING	L. EPSDT
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.	20. TOTAL CHARGES →	LESS ↓	MEDICARE SPR DATE
27. SIGNATURE (SUBJECT TO CERTIFICATION ON REVERSE) DATE	30. REMARKS	21. MEDICARE PAID	24. MEDICARE DEDUCTIBLE
28. BILLING PROVIDER NAME		22. THIRD PARTY PAID	25. MEDICARE COINSURANCE
29. BILLING PROVIDER NUMBER		23. NET CHARGE	26. MEDICARE DISALLOWED