

1500

Non-covered by Medicare

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																																															
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0098765432																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MILLER JACK										3. PATIENT'S BIRTH DATE MM DD YY 05 15 1930 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) MILLER JACK																																																																					
5. PATIENT'S ADDRESS (No., Street) 111 PARADISE DRIVE										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) 111 PARADISE DRIVE																																																																					
CITY LANSING					STATE MI					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY LANSING					STATE MI																																																																					
ZIP CODE 48913					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 48913					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 212131313A																																																																					
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY 05 15 1930 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>																																																																					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																																																					
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME MEDICARE PART B WPS																																																																					
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																					
<p align="center">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</p> 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 Y DATE 12/30/2008																				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 SIGNATURE ON FILE																																																																					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SMITH KAREN										17a. NPI					17b. NPI 1212333412					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 12 04 2008 TO 12 17 2008																																																																					
19. RESERVED FOR LOCAL USE Other insurance applied to deductible																				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																																											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V70 3 2. 3. 4.																				23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 12 04 08 12 04 08																																																											
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. #																																																	
21					Y					99381					26					GY					41 00					1					NPI					1809698526																																																	
<table border="1"> <thead> <tr> <th colspan="10">CAS Codes/Other Insurance Information</th> </tr> <tr> <th>Payor</th> <th>Line</th> <th>Group Cd</th> <th>Reason Cd</th> <th>Amount/Date</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>1</td> <td>CO</td> <td>96</td> <td>41.00</td> </tr> <tr> <td>2.</td> <td>1</td> <td>CO</td> <td>DTPD</td> <td>120408</td> </tr> <tr> <td>3.</td> <td>1</td> <td>CO</td> <td>PD</td> <td>0.00</td> </tr> </tbody> </table>																				CAS Codes/Other Insurance Information										Payor	Line	Group Cd	Reason Cd	Amount/Date	1.	1	CO	96	41.00	2.	1	CO	DTPD	120408	3.	1	CO	PD	0.00	25. FEDERAL TAX I.D. NUMBER 383434111										SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>					26. PATIENT'S ACCOUNT NO. IG741258					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 41 00					29. AMOUNT PAID \$ 0 00					30. BALANCE DUE \$ 41 00				
CAS Codes/Other Insurance Information																																																																																									
Payor	Line	Group Cd	Reason Cd	Amount/Date																																																																																					
1.	1	CO	96	41.00																																																																																					
2.	1	CO	DTPD	120408																																																																																					
3.	1	CO	PD	0.00																																																																																					
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.) THOMAS SMITH MD										32. SERVICE FACILITY LOCATION INFORMATION MICHIGAN GENERAL HOSPITAL 100 MEDICAID STREET LANSING MI 48909										33. BILLING PROVIDER INFO & PH # () RADIOLOGY OFFICE 222 MICHIGAN ST LANSING MI 48909																																																																					
SIGNED										DATE 12/30/2008					a 131122343					b.					a 121113214					b.																																																											

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION