

HEALTH INSURANCE CLAIM FORM

ORAL & MAXILLOFACIAL SURGEONS ONLY

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										4. INSURED'S NAME (Last Name, First Name, Middle Initial) 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) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
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 <u>SOE</u> DATE <u>00/00/00</u>										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 _____									
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <u>V72 2</u> (Optional) "Y" if emergency 2. _____ 3. _____ 4. _____										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____									
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										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
1 XX XX XX XX XX XX 11 Y 99202										F. \$ CHARGES 60 00 G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL NPI 1D ZX0000 J. RENDERING PROVIDER ID. # XXXXXXXXXXXX									
2 XX XX XX XX XX XX 11 Y 20670										F. \$ CHARGES 260 00 G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL NPI 1D ZX0000 J. RENDERING PROVIDER ID. # XXXXXXXXXXXX									
3										F. \$ CHARGES I. ID. QUAL NPI									
4										F. \$ CHARGES I. ID. QUAL NPI									
5										F. \$ CHARGES I. ID. QUAL NPI									
6										F. \$ CHARGES I. ID. QUAL NPI									
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. SMITHMARY									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ 320 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 320 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.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION. <u>Complete if services were rendered in a facility other than the patients home or prov office.</u>									
33. BILLING PROVIDER INFO & PH # () Put "pay-to" provider in this field.										XXXXXXXXXX 1DXXXXXX XXXXXXXXXXXX 1DZA0000									

NUCC Instruction Manual available at: www.nucc.org

On & after 5/23/07: ZZ followed by Taxonomy code

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

On & after 5/23/07: ZZ followed by Taxonomy code

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

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"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE TELEPHONE (Include Area Code)	CITY STATE
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) XXXXXXXXXX	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
a. OTHER INSURED'S POLICY OR GROUP NUMBER	11. INSURED'S POLICY GROUP OR FECA NUMBER XXXXXXXXXX
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME \$25.00	b. EMPLOYER'S NAME OR SCHOOL NAME \$15.00
d. INSURANCE PLAN NAME OR PROGRAM NAME 401	c. INSURANCE PLAN NAME OR PROGRAM NAME 132
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 <u>SOF</u> DATE <u>00/00/00</u>	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 _____
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 17a. _____ 17b. NPI _____
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <u>V72 2 (Optional)</u> "Y" if emergency 2. _____ 3. _____ 4. _____
22. MEDICAID 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 EMG CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	25. FEDERAL TAX I.D. NUMBER SSN EIN
1 XX XX XX XX XX XX 11 Y 99202 60 00 1D ZX0000 NPI XXXXXXXXXXXX	26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO
2 XX XX XX XX XX XX 11 Y 20670 260 00 1D ZX0000 NPI XXXXXXXXXXXX	28. TOTAL CHARGE \$ 320 00 29. AMOUNT PAID \$ 40 00 30. BALANCE DUE \$ 280 00
3 NPI	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.)
4 NPI	32. SERVICE FACILITY LOCATION INFORMATION Complete if services were rendered in a facility other than the patients home or prov office.
5 NPI	33. BILLING PROVIDER INFO & PH# Put "pay-to" provider in this field.
6 NPI	SIGNED _____ DATE _____

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION