

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1 MEDICARE	MEDICAID		CARE		CHAMPV		GROUP HEALTH	PLAN _	FECA BUK LI	UNG ,—	7	1a, INSURED'S I.D. N	IUMBER		(Fo	r Program in	Item 1)
(Medicare#)	(Medicald#)	ш.	(DoD#)	الماء	(Member IE	كاث	(ID#)		(#D#)		(NOII)	. Wallechie	// 141	-		A 101 B	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE SEX					F	4. INSURED'S NAME (Last Name First Name Middle Initial)					
5. PATIENT'S ADDR	ESS (No., Stre	et)				6. PA	TIENT REL	ATIONS	HIP TO II	NSURE		7. INSURED'S ADDR	ESS (No. S	treet)			
						Se	If Spo	use	Child	Oth	er						
CITY					STATE	8. RE	SERVED F	OR NUC	C USE	234		CITY				S	TATE
ZIP CODE	1-	TELEPHON	JE (Include	Aren C	Code)							ZIP CODE		TC! EDUC	N (F 111	- da A O	4-3
ZIP CODE TELEPHONE (Include Area Code)												TELEPHONE (Include Area Code)					
9. OTHER INSURED	'S NAME (Last	Name, Fir	st Name, N	Alddle I	nitial)	10. IS	PATIENT'S	S CONDI	TION RE	LATED :	ro:	11. INSURED'S POLI	CY GROUP	OR FECA	VUMBER	٦	-
0.000																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER							PLOYMEN	T? (Curre	ent or Pre	vious)		a. INSURED'S DATE OF BIRTH SEX					
h DESERVED FOR	NILICO LISE					YES NO						M F					
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? PLACE (State)					E (State)	b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR I	NUCC USE				_	c. OTHER ACCIDENT?						C. INSURANCE PLAN NAME OR PROGRAM NAME					
								YES		NO		S. HOS. INTOC. I DAIL HAIRE ON PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME							LAIM COD	ES (Des	ignated b	y NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
												YES NO If yes, complete items 9, 9a, and 9d.					
12 PATIENT'S OR A	UTHORIZED P	PERSON'S	SIGNATU	RE Lat	MPLETING uthorize the r	elease	of any medi	cal or oth	ner informa	ation nec	essary	13. INSURED'S OR All payment of medical					
to process this cla below.	im. I also reque	st payment	of governn	nent bei	nelits either t	o myse	If or to the p	arty who	accepts a	assignme	ent	services described		Wie dilidara	giroa pir	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	appilor for
SIGNED							DATE					SIGNED					
	ENT ILLNESS,	INJURY, o	r PREGN	NCY (L	.MP) 15. C	THER	-					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 15. OTT OUAL OUAL							MM DD YY					FROM DD YY MM DD YY					
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.												18. HOSPITALIZATION	N DATES RI	ELATED TO	CURRI	ENT SERVIO	CES
17b 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							NPI					FROM TO					
19. ADDITIONAL CL	AIM INFORMA	HON (Desi	gnated by	NUCC)								20. OUTSIDE LAB?	1	\$	CHARG	ES	
21 DIAGNOSIS OR I	NATURE OF IL	LNESS OF	Y INJURY	Relate	A-L to service	e line l	below (24E)		of F	_	YES YES UBMISSION	NO				
A 1					c L		•-	' ICE) Ind	18		22 RESUBMISSION CODE	I	ORIGINAL	REF. NO).	
A.L B.L C.L. E.L F.L G.L.						D						23. PRIOR AUTHORIZATION NUMBER					
4.1		J			к. L		11 10		L L								
24 A. DATE(S)	OF SERVICE To		B. PLACE OF	C.	D. PROCED (E plai		, SERVICE		UPPLIES		E GNOSIS	F	G. DAYS OR	H. I		J. RENDEI	RING
MM DD YY	MM DD	YY	SERVICE E	MG	CPT/HCPC	S	Hillian	MODIFIE	R	PC	INTER	\$ CHARGES		Plan QUAL		PROVIDE	RID.#
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25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PA				6. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT					ENT?	28. TOTAL CHARGE 29 AMOUNT PAID 30. Rsvd for NUCC Use							
31 SIGNATURE OF	PHYSICIANIOS	SUBBLIE		22 57	DVICE CAS	H PTV -	OCATION		YES	NO		\$	\$	7			
INCLUDING DEGREES OR CREDENTIALS						ALHY I	ILITY LOCATION INFORMATION					33. BILLING PROVIDE	H INFO & P	н# ()		
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)																	
SIGNED		DATE		a.			b					а.,	þ				
		BRIE															

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's componsation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See #2 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge defundation of the Medicare carrier or TRICARE fiscal intermediary if this is toss than the charge submitted TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete, 2) I have familianzed myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law), 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license # or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional service, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims. I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (rofer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or faisifies 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, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs 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 these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carner Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13. ESA-30. or as updated and republished.

FOR-TRICARE-CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civillan sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law

HOUTINE USE(S); Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no ponalties under those programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as alle necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services fisted above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction

NOTICE: This is to certify that the foregoing information is true, accurate and complete. Lunderstand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources gather the data needed, and complete and leview the information collection. If you have any comments concerning the accuracy of the time oslimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4 26-05. Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.