1 Provider Name Provider Address City, State Zip Code	2 Pay-To Provider Name Pay-To Provider Address City, State Zip Code	3a PAT. CNTL # Text b. MED. REC. #	4 TYPE OF BILL XXXX
		5 FED. TAX NO. Federal Tax ID	6 STATEMENT COVERS PERIOD FROM DOS From THROUGH - Through

8 PATIENT NAME	a	9 PATIENT ADDRESS	a Patient Address
b Patient's Name (Last, First, Middle Initial)		b City	c State d Zip Code e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
MMDDYYYY	M/F	MMDDYY	XX	X	X		XX	XX											XX	

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 THROUGH	37
a														a
b														b

38	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
Responsible Party's Name (last, First, Middle Initial) *Responsible Party's Address* *City, State Zip Code*	a					
	b					
	c					
	d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	XXXX	**Description**, *NDC*	*HCPCS/Raate/HIPPS Code*	MMDDYY	XX	XXX XX		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE X OF X	CREATION DATE			XXX XX		23

A	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	NPI Required
A	San Francisco Health Plan				XXX XX		57	
B	Patient's Medical Group						OTHER	
C							PRV ID	

A	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Patient's Name (Last, First, Middle Initial)		SFHP ID (XXXXXXXXXXX)		
B					
C					

A	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	*Authorization Code*		
B			
C			

66 DX	A	B	C	D	E	F	G	H	68
XXXXX	I	J	K	L	M	N	O	P	Q	XXXXX
X									

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73
XXXXX										

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
XXXXX	MMDDYY	XXXXX	MMDDYY	XXXXX	MMDDYY	

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS	81CC		
Remarks	a		
	b		
	c		
	d		

76 ATTENDING	NPI NPI Required	QUAL XX	XXXXXX
LAST Attending's Last Name		FIRST Attending's First name	
77 OPERATING	NPI *NPI*	QUAL *XX*	*XXXXXX*
LAST *Operating's Last Name*		FIRST *Operating's First Name*	
78 OTHER	NPI *NPI*	QUAL *XX*	*XXXXXX*
LAST *Other's Last Name*		FIRST *Other's First Name*	
79 OTHER	NPI *NPI*	QUAL *XX*	*XXXXXX*
LAST *Other's Last Name*		FIRST *Other's First Name*	

SAMPLE