

North Carolina Medicaid Special Bulletin



Please visit us at our website at www.dhhs.state.nc.us/dma.

September

2005

Attention: All Providers of Enhanced Benefit Mental/Substance Abuse Services Phase I

****PLEASE NOTE:** The agenda for the upcoming seminar in September has been modified. Only the following services are going to be discussed in this seminar:

Community Support-Adult (Individual and Group)
Community Support-Child (Individual and Group)
Mobile Crisis Management
Diagnostic Assessment
Intensive In-Home
Multisystemic Therapy (MST)
Community Support Teams (adult) (CST)
Assertive Community Treatment Team (ACTT)
Psychosocial Rehabilitation
Partial Hospital

*Evaluation/Assessments/Individual Outpatient Psychotherapy/Outpatient Family Therapy/Group Therapy will not be addressed in this session. Training for these services occurred in Jan and May of this year. The remaining Enhanced Benefit Services will be covered at a seminar in early 2006. Please reference the September 2005 Special Bulletin Providers of Enhanced Benefit Mental Health/Substance Abuse Services for additional information pertaining to the services mentioned above. Please watch for additional details in future Medicaid Bulletins.

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Introduction

As part of Mental Health Reform, the endorsement process for enrollment for Enhanced Benefit Mental Health/Substance Abuse Services will start in September 2005. Due to the size and complexity of these services, the training process will occur in two phases. This Phase 1 training will discuss only the 10 Enhanced Benefit Mental Health Services listed on the cover. Training for the additional 11 Services, which include Substance Abuse Services, will be conducted in February 2006. These services will not be implemented until approval of the State Plan Amendment from CMS has been granted.

This bulletin will only address Phase I service definitions that will be endorsed from 9/1/2005 through 2/28/2006. Phase II service definitions will be addressed in a future special bulletin.

A brief summary of the Phase I service definitions along with billing guidelines are contained in this bulletin. Please refer to the DMA website <http://www.dhhs.state.nc.us/dma> for the complete service definition which includes all the specific requirements, limitations, and provider qualifications for each definition.

Provider Enrollment

Providers must be endorsed by the LME (local management entity) for each service before enrolling as a Medicaid provider. Information about the endorsement process can be found on the DMH (Division of Mental Health) website at <http://www.dhhs.state.nc.us/mhddsas>.

After endorsement, providers must complete and sign a Medicaid provider enrollment application and agreement. The application and instructions will be located on the Division of Medicaid Assistance (DMA) website at <http://www.dhhs.state.nc.us/dma/provenroll.htm>. Completed application and all attachments must be mailed to the: DMA Provider Services, Attn: Mental Health Enrollment Specialist, 2501 Mail Service Center, Raleigh, NC 27699-2501. Please remember to complete and attach postage to the application acknowledgement card if you wish to be notified that DMA has received your application.

Once the application is approved, the provider will be issued a core Medicaid provider number to be used as the billing provider number. As the provider enrolls for each service they wish to provide, they will be issued an additional attending provider number, which is the core number with an alpha suffix.

NOTE: For each service providers wish to provide, they must be enrolled and endorsed to receive reimbursement. Each of the 22 Enhanced Benefit Mental Health/Substance Abuse services require a separate endorsement, enrollment application addendum, and alpha suffix to be added to the core billing number.

The following table outlines each service and the alpha suffix that will be assigned as providers are endorsed and enrolled for a particular service.

Alpha Character	Service
A	Assertive Community Treatment Team (ACTT)
B	Community Support-Child
B	Community Support – Adult
B	Community Support Group – Child and Adult
B	Community Support Teams (CST)
F	Mobile Crisis Management

Alpha Character	Service
G	Diagnostic Assessment
H	Intensive In-Home
I	Multisystemic Therapy (MST)
S	Psychosocial Rehabilitation
D	Partial Hospital

Eligible Recipients

Medicaid eligible recipients may have service restrictions due to their eligibility category that would make them ineligible for Mental Health services.

Special Provision

For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the NC State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Any denial, reduction, suspension or termination of a service requires notification to the recipient and/or legal guardian about their appeal rights.

Service Definitions

1. Community Support Adult – H0036 HB (Individual) H0036 HQ (Group)

This service is available to adults and will become the “clinical home” of the adult. The interventions include training of the care giver, preventive, developmental and therapeutic activities that will assist with skill building, development of a person centered plan, relational skills, symptom monitoring, therapeutic mentoring and case management functions of arranging, linking, referring to services and monitoring of provision of services. The providers of this service will also serve as a first responder in a crisis situation. The service must be ordered by a physician, licensed psychologist, physician’s assistant, or nurse practitioner prior to or on the day that the services are to be provided. The Community Support provider organization will be authorized by the LME for an initial thirty (30) days in which the Diagnostic Assessment and PCP (person centered plan) will be completed. Subsequent authorizations will be required by the approved LME or the state vendor. The Community Support provider organization will be identified in the PCP and is responsible for obtaining authorization from the LME for the PCP.

Provider and Staffing Requirements:

The service will be provided as an agency based service with qualified professionals, paraprofessionals and associate professionals who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment. The provider qualifications for the AP (Associate Professional), Paraprofessional, and Qualified Professional may be found in the NC Administrative Code T10A 27 G.

Service Limitations:

An individual can receive Community Support services from only one Community Support provider organization at a time and cannot be billed on the same day as Psychosocial Rehabilitation Group Services. **Community Support services can only be billed a maximum of eight (8) units per month for individuals receiving any of the following services:** Partial Hospitalization, Substance Abuse Comprehensive Outpatient Treatment (SACOT), Substance Abuse Intensive Outpatient Program (SAIOP), or Substance Abuse Non-Medical Community Residential Treatment. The individual Person Centered Plan (PCP) must specify the reason for Community Support services during the same authorization period as the above services.

This service will be billed in fifteen (15) minute increments.

This service should be billed with the alpha character B appended to the attending provider number.

2. Community Support Child – H0036 HA (Individual) H0036 HQ (Group)

This service is available to children from age 3 through age 20 and will become the “clinical home” of the child. The interventions include training of the care giver, preventive, developmental and therapeutic activities that will assist with skill building, development of a person centered plan, relational skills, symptom monitoring, therapeutic mentoring and case management functions of arranging, linking, referring to services and monitoring of provision of services. The service must be ordered by a physician, licensed psychologist, physician’s assistant or nurse practitioner. The providers of this service will also serve as a first responder in a crisis situation. The Community Support provider organization will be authorized by the LME for an initial thirty (30) days in which the Diagnostic Assessment and PCP (person centered plan) will be completed. Subsequent authorizations will be required by the approved LME or the state vendor. The Community Support provider organization will be identified in the PCP and is responsible for obtaining authorization from the LME for the PCP.

Provider and Staffing Requirements:

The service will also be provided as an agency based service with qualified professionals, paraprofessionals and associate professionals who must have 20 hours of training specific to the requirements of the service definition within the first 90 days of employment. The provider qualifications for the AP (Associate Professional), Paraprofessional, and Qualified Professional may be found in the NC Administrative Code T10A 27 G.

Service Limitations:

An individual can receive Community Support services from only one Community Support provider organization at a time. **Community Support services can only be billed a maximum of eight (8) units per month for individuals receiving any of the following services:** Intensive In-Home service, Multisystemic Therapy (MST), Substance Abuse Intensive Outpatient Program (SAIOP), Day Treatment, Level II-IV Child Residential or Substance Abuse Residential services.

This service will be billed in fifteen (15) minute increments.

This service should be billed with the alpha character B appended to the attending provider number.

3. Mobile Crisis Management – H2011

This involves all supports, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions and crisis prevention activities. It is available 24/7/365 and provides immediate evaluation, triage and access to acute mental health, developmental disability, and substance abuse (mh/dd/sas) services, treatment, supports to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for stabilization.

Provider and Staffing Requirements:

It is provided by a team that includes Qualified Professionals according to 10A NCAC 27G and who must be a nurse, a clinical social worker or psychologist as defined by this administrative code. Teams include substance abuse professionals and a board certified or eligible psychiatrist must be available for face to face or phone consultation to crisis staff.

Paraprofessionals with crisis management experience may also be included on the team but must work under the supervision of a professional. Experience with the population is required and 20 hours of crisis intervention training within the first 90 days of employment is necessary.

Service Limitations:

This service has a limitation; however, the nature of the service requires stabilization or movement into an environment that can stabilize so it is not a termination of service. The maximum length of the service is 24 hours per episode, prior approval will be required by the approved LME or state vendor. after the first 8 hours for the remaining 16 hours. Mobile Crisis Management should be used to divert individuals from inpatient psychiatric and detoxification services. These services are not used as “step down” services from inpatient hospitalization.

This service will be billed by units of fifteen (15) minute increments.

This service should be billed with the alpha character F appended to the attending provider number.

4. Diagnostic Assessment – T1023

This is an intensive clinical face to face evaluation of a recipient’s mh/dd/sas (mental health, developmental disability, substance abuse) condition that will act as a determining factor for the enhanced benefit package of services. This Diagnostic/Assessment report will include an order for the Enhanced Benefit services that provides the basis for the development of the PCP.

Provider and Staffing Requirements:

The assessment will be signed and dated by the Medical Doctor, DO (doctor of osteopathy), Physicians Assistant, Nurse Practitioner, or licensed psychologist and will serve as the initial order for the services included in the PCP. The Diagnostic/Assessment team must include at least two Qualified Professionals according to 10A NCAC 27G, both of whom are licensed or certified clinicians; one of the team members must be a qualified practitioner whose professional licensure authorizes the practitioner to diagnosis mental illnesses and/or addictive disorders. One of which must be a physician, DO, nurse practitioner, physicians assistant, or licensed psychologist.

Service Limitations:

A recipient may receive one (1) Diagnostic/Assessment per year. Any additional Diagnostic/Assessment within a one (1) year period must be authorized by the LME or state vendor prior to the delivery of the service. For additional services added after the development of the initial person centered plan, the order requirement for each service is included in the service definitions that can be found on the DMA website: <http://www.dhhs.state.nc.us/dma>. If psychological testing or specialized assessments are indicated, they are to be billed separately using CPT codes 96100, 96110, 96111, 96115, or 96117.

This service will be billed by event, which is defined as a complete assessment from two different disciplines as defined above.

This service should be billed with the alpha character G appended to the attending provider number.

5. Intensive In-Home – H2022

This is a time limited service that can be provided through age 20 to diffuse current crisis, intervene to reduce likelihood of re-occurrence, ensure linkage to community services and resources, monitor and manage presenting psychiatric and/or addictions symptoms, skills trainings and other rehabilitative supports to prevent out of home placement for the child. **The service requires a minimum of 12 face to face contacts the first month with a contact being defined as all visits within a 24 hour period. A minimum of 2 hours of service must be provided before the service is billable.** Number of visits per month for the second and third month of the service will be titrated with the expectation of six visits per month. There are limitations on the provisions of other services to prevent duplication. The service must be ordered by a physician, licensed psychologist, physician’s assistant, or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the approved LME or state vendor.

Provider and Staffing Requirements:

This is a team service provided by qualified professionals, associate professionals and paraprofessionals according to 10A NCAC 27G. There is a team to family ratio to keep case load manageable and staff must have a minimum of one (1) year documented experience with this population and must complete intensive in home training with in the first 90 days of employment.

Service Limitations:

An individual can receive Intensive In-Home services from only one Intensive In-Home provider organization at a time. Services are provided in the home or community and are not billable for children in detention or inpatient settings. This service is not delivered in a group setting.

This service is billed on a per diem basis.

This service should be billed with the alpha character H appended to the attending provider number.

6. Multisystemic Therapy (MST) – H2033

This program is designed for youth between the ages of 7 and 17 who have antisocial, aggressive/violent behaviors and are at risk for out of home placement due to delinquency; adjudicated youth returning from out of home placement and/or chronic or violent juvenile offenders; and youths with serious emotional disturbances or abusing substances. This is a team service that has the ability to provide service 24/7/365. The services include assessment, individual therapeutic interventions with the youth and family, case management, crisis stabilization, and respite. Specialized therapeutic interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. The service must be ordered by a physician, licensed psychologist, physician's assistant, or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the approved LME or state vendor.

Provider and Staffing Requirements:

The provider qualifications are at a minimum a master's level QP who is the team supervisor and three QP staff (qualifications according to 10A NCAC 27G). Staff is required to participate in MST introductory training and quarterly training on topics related to the needs of MST youth and their family on an ongoing basis. All MST staff shall receive a minimum of one (1) hour of group supervision and one hour of telephone consultation per week. Limitations are in place to prevent reimbursement for duplication of services. MST team member to family ratio shall not exceed one to five (1 to 5) for each member.

Service Limitations:

An individual can receive Multisystemic Therapy services from only one Multisystemic Therapy provider organization at a time. A minimum of twelve (12) contacts are required within the first month of the service and for the next two months an average of 6 contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

This service will be billed by units of fifteen (15) minute increments.

This service should be billed with the alpha character I appended to the attending provider number.

7. Community Support Teams (adults) (CST) – H2015 HT

Services provided by this team consist of mental health and substance abuse services and supports necessary to assist adults (18 and older) in achieving rehabilitation and recovery goals. It assists individuals to gain access to necessary services: reduce psychiatric and addiction symptoms; and develop optimal community living skills. The services include assistance and support to individuals in crisis situation; service coordination; psycho education and support for individuals and their families; independent living skills; development of symptom monitoring and management skills, monitoring medications and self-medication. The CST provider assumes the role of advocate, broker, coordinator and monitor of the service delivery system on the behalf of the recipient. A service order for CST must be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner. Prior approval will be required by the approved LME or state vendor.

Provider and Staffing Requirements:

A CST team will be comprised of 3 staff persons one of which is the team leader and must be a QP. The other two may be a QP, AP or a paraprofessional (qualifications according to 10A NCAC 27G). The team maintains a consumer to practitioner ratio of no more than fifteen consumers per staff person. All staff providing this service must have a minimum of one year documented experience with the adult population and completion of a minimum of twenty hours of crisis management and community support team service definition required within the first 90 days of hire.

Service Limitations:

An individual can receive Community Support services from only one Community Support services provider organization at a time.

This service will be billed by units of fifteen (15) minute increments.

This service should be billed with the alpha character B appended to the attending provider number.

8. Assertive Community Treatment Team (ACTT) – H0040

This existing service is provided by a multidisciplinary team to recipients when it has been determined that the needs are so pervasive and/or unpredictable that they cannot be met by a combination of other services. The team provides evaluations (an assessment to determine the extent of the problems), outpatient treatment, case management, and community based services (described below) for individuals with mental health and substance abuse diagnoses. These are all bundled into therapeutic interventions and include crisis response as the first responder. It is available 24/7/365, in any location (except jails, detention centers, clinic settings and hospital inpatient settings) recipient to staff ratio is 10-1 with a maximum of 12-1. The service must be ordered by a physician, licensed psychologist, physician's assistant, or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the approved LME or state vendor.

Provider and Staffing Requirements:

Minimum staff per team is a qualified professional staff, para-professional staff (qualifications according to 10A NCAC 27G), RN, certified peer specialist, and .25 FTE physicians for every 50 clients. The team is employed by an agency that has contracted with the LME to provide this service.

Service Limitations:

An individual can receive ACTT services from only one ACTT provider organization at a time. There must be a minimum of 4 face to face contacts per month by any member of the team (this is billed per diem but the system is set so it will not reimburse for more than 4 in 1 month); the service is intended to provide support and guidance in all areas of functional domains to enhance the recipient's ability to remain in the community. **No other periodic mental health services can be billed in conjunction with this service.**

This service will be billed per event.

This service should be billed with the alpha character A appended to the attending provider number.

9. Psychosocial Rehabilitation – H2017

This service provides skill development activities, life skills development to support educational progress and pre-vocational training to adults and elderly adults who have serious mental illness or severe and persistent mental illness. It is provided under the supervision of a physician and is available for a period of 5 or more hours per day at least five day per week and it may be provided on weekends or in the evening. The interventions must be included in a treatment plan and may be any of the following: behavioral interventions/management, social and other skill development, adaptive skill training, enhancement of communication and problem solving skills, anger management, family support, medication monitoring, monitoring of changes in psychiatric symptoms/or functioning and positive reinforcement. It is provided in a licensed facility with staff to recipient ratio of 1:8. This service is provided to outpatients in accordance with 42 CFR 440.90 by an area program that is not a part of a hospital but provides medical care to outpatients by or under the direction of a physician. The service must be ordered by a physician, licensed psychologist, physician's assistant, or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the approved LME or state vendor.

Staffing and Provider Requirements:

Psychosocial Rehabilitation services must be delivered by a mental health provider organization that meets the provider qualifications established by DMH (Division of Mental Health) and the requirements of 10A NCAC 27G.

Service Limitations:

An individual can receive psychosocial rehabilitation services from only one Psychosocial Rehabilitation provider organization at a time. Psychosocial Rehabilitation is a service that shall be available five hours a day minimally and the setting shall meet the licensure requirements of 10A NCAC 27G.1200. The amount, duration, and frequency of services must be included in the individual PCP and authorized on or before the day services are to be provided. Community Support group cannot be provided to an individual on the same day as Psychosocial Rehabilitation

Initial authorization for services must not exceed a six (6) month period.

This service will be billed in fifteen (15) minute increments.

This service should be billed with the alpha character S appended to the attending provider number.

10. Partial Hospital – H0035

This is a service for adults that will be used as an interim treatment for the prevention of an acute hospitalization or as a step down from an acute hospitalization. This service may be used for children when associated with a special treatment program (i.e. an eating disorder program). The service must be ordered by a physician, licensed psychologist, physician's assistant, or nurse practitioner prior to or on the day that the services are to be provided. Prior approval will be required by the approved LME or state vendor.

Provider and Staffing Requirements:

A physician must participate in diagnosis, treatment planning, and admission/discharge decisions.

Service Limitation:

The current specialized program is located in a hospital setting and is staffed according to JCAHO requirements.

This service will be billed on a per diem basis.

This service should be billed with the alpha character D appended to the attending provider number.

11. Evaluation/Assessments/Individual Outpatient Psycho-therapy/Outpatient Family Therapy/ Group Therapy

The January 2005 and May 2005 Medicaid Special Bulletins contain information about this service, the provider types, and billing information. These bulletins are posted on the DMA website <http://www.dhhs.state.nc.us/dma>.

These services are billed with the following procedure codes:

HCPCS Code	Alpha Character	Service
H0040	A	Assertive Community Treatment Team (ACTT)
H0036HA	B	Community Support-Child
H0036HB	B	Community Support – Adult
H0036 HQ	B	Community Support Group – Child and Adult
H2015HT	B	Community Support Teams (CST)
H2011	F	Mobile Crisis Management
T1023	G	Diagnostic Assessment
H2022	H	Intensive In-Home
H2033	I	Multisystemic Therapy (MST)
H2017	S	Psychosocial Rehabilitation
H0035	D	Partial Hospital

Instructions for Completing a Claim for Enhanced Benefit Mental Health/Substance Abuse Services

Refer to the following information for completing a CMS-1500 claim form for the above services.

Block #/Description	Instruction
1.	Place an X in the MEDICAID block.
1a. Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) exactly as it is shown on the recipient's Medicaid ID card.
2. Recipient's Name	Enter the recipient's last name, first name and middle initial exactly as it is shown on the Medicaid ID card.
3. Recipient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth - MMDDYYYY. The birth date is on the Medicaid ID card. EXAMPLE: November 14, 1949 is 11141949 . Place an X in the appropriate block to show the recipient's sex.
4. Insured's Name.	Leave blank
5. Recipient's Address	Enter the recipient's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6. – 8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name.
9a. – 9d.	Enter applicable insurance information.
10. Is Recipient's Condition...?	Place an X in the appropriate block for each question.
11. – 14.	Optional.
15. – 16.	Leave blank.
17., 17a., and 18.	Optional.
19. Reserved for Local Use	Leave blank.
20. Outside Lab...	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization Number	Leave blank.

Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail." When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line.
- Include only dates of service for which the recipient is eligible for Medicaid.

Block #/Description	Instruction
24a. Date(s) of Service, From/To	Enter the date of service in the "From" date field and then the same date in the "To" date field.
24b. Place of Service	Enter the appropriate place of service code.
24c. Type of Services	Leave blank.
24d. Procedures, Services...	Enter the appropriate HCPC code and modifier (if applicable) for the service being provided.
24e. Diagnosis Code	Leave blank.
24f. Charges	Enter the total charge for the items on the line.
24g. Days or Units	Enter the number of units. (i.e. 1unit = 15 minutes or 1 unit = 1 day)
24h. – 24i.	Leave blank.
24j. – 24k.	Optional.
25. Federal Tax ID Number	Optional
26. Recipient's Account No.	Optional. You may enter your agency's record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27. Accept Assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in Item 24F .
29. Amount Paid	Enter the total amount received from third party payment sources if service is subject to Third Party.
30. Balance Due	Subtract the amount in Item 29 from the amount in Item 28 and enter the result here.
31. Signature of Physician or Supplier...	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.

Block #/Description	Instruction
32. Name and Address of Facility...	Optional.
33. Physician's/ Supplier's Billing Name...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid participation agreement.
PIN#	Enter your seven-digit Medicaid attending provider number with the appropriate alpha character which defines the service being provided.
GRP#	Enter your seven-digit Medicaid billing provider number.

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Community Supports
Adult

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) (Medicaid #) (Spouse's SSN) (VA File #) (SSN or ID) (SSN) (IC)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane, D.

3. PATIENT'S BIRTH DATE
MM DD YY
09 22 1960 M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
999999999T

5. PATIENT'S ADDRESS (No., Street)
123 Any Street

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY Any Town STATE NC

8. PATIENT STATUS
Single Married Other

CITY STATE

ZIP CODE 12345 TELEPHONE (Include Area Code) (919) 123-4567

Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT? PLACE (State) YES NO
c. OTHER ACCIDENT? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

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 _____ DATE _____

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(S), MP? 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 PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 290 3. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24	A	B	C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE FROM	DATE(S) OF SERVICE TO	Place of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS EPISODE OR UNITS	Plan	EMG	COB	RESERVED FOR LOCAL USE
1	10 15 05	10 15 05	12	H0036 HB		65 00	4				
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE \$ 65 00

29. AMOUNT PAID \$

30. BALANCE DUE \$ 65 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
A. Provider 10/15/05
SIGNED _____ DATE _____

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Any Provider
12 Any Street
Anytown, NC 12345
SIN# 8300000B GRP# 8300000

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE (6/98) PLEASE PRINT OR TYPE APPROVED OMB-0856-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-12-15-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Community Supports Group
No Age Limitation

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input checked="" type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA BLK LUNG <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM ITEM 1)	999999999T				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.				3. PATIENT'S BIRTH DATE MM DD YY M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street) 123 Any Street				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 Any Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE				
ZIP CODE 12345		TELEPHONE (Include Area Code) (919) 123-4567		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE		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						
a. OTHER INSURED'S POLICY OR GROUP NUMBER				4. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M F						
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F				5. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME				6. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i>						
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.								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 _____				DATE _____		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 PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		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)				22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.						
1. 290				3. _____		23. PRIOR AUTHORIZATION NUMBER						
2. _____				4. _____								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER		E. DIAGNOSIS CODE	F. \$ CHARGES	G. DAYS OR UNITS	H. ESRPT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
10 07 05 10 07 05 99				H0036 HQ			25 00	4				
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For div. cases, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE & PHONE #	29. AMOUNT PAID	30. BALANCE DUE			
							\$ 25 00	\$	\$ 25 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.) A. Provider 10/7/05 SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 12 Any Street Anytown, NC 12345 PRN 83000008 GRP 83000000				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Examples

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Community Supports
Child

CARRIER

HEALTH INSURANCE CLAIM FORM													
1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <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) 999999999T			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.				3. PATIENT'S BIRTH DATE MM DD YY 08 11 1987 M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 123 Any Street				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 Any Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY		STATE			
ZIP CODE 12345		TELEPHONE (include Area Code) (919) 123-4567		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE		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					
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 M <input 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? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				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					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete Item 9 a-d.</i>					
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 _____ DATE _____													
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 PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input 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. 290				22. PRIOR AUTHORIZATION NUMBER				23. PRIOR AUTHORIZATION NUMBER					
24. TABLE OF SERVICES													
A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY		B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-PCS / MODIFIER		E. DIAGNOSIS CODE	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9 Family Plan	I. EMB	J. COB	K. RESERVED FOR LOCAL USE	
10 10 05 10 10 05		12		H0036 HA			65 00	4					
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For prov. claim, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 65.00	29. AMOUNT PAID \$	30. BALANCE DUE \$ 65.00				
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.) A. Provider 10/10/05 SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 12 Any Street Anytown, NC 12345 HWR 8300000B GRP 8300000					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Examples

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Mobile Crisis Management
No Age Limitation

CARRIER

HEALTH INSURANCE CLAIM FORM

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or IC) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER		13. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999T																																																																																									
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CITY: Any Town STATE: NC		CITY: STATE:																																																																																									
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4.		24. TABLE OF SERVICES																																																																																									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <th>DATE(S) OF SERVICE FROM</th> <th>TO</th> <th>Place of Service</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (explain Unusual Circumstances) CPT/HCPCS / MODIFIER</th> <th>DIAGNOSIS CODE</th> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EMG</th> <th>COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>10/22/05</td> <td>10/22/05</td> <td>12</td> <td>H2011</td> <td></td> <td>130.00</td> <td>4</td> <td></td> <td></td> <td colspan="2"></td> </tr> <tr> <td> </td> <td colspan="2"> </td> </tr> <tr> <td> </td> <td colspan="2"> </td> </tr> <tr> <td> </td> <td colspan="2"> </td> </tr> <tr> <td> </td> <td colspan="2"> </td> </tr> <tr> <td> </td> <td colspan="2"> </td> </tr> </tbody> </table>		A	B	C	D	E	F	G	H	I	J	K	DATE(S) OF SERVICE FROM	TO	Place of Service	PROCEDURES, SERVICES, OR SUPPLIES (explain Unusual Circumstances) CPT/HCPCS / MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EMG	COB	RESERVED FOR LOCAL USE		10/22/05	10/22/05	12	H2011		130.00	4																																																												25. FEDERAL TAX I.D. NUMBER SSN EIN	
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26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For joint claims, see back) YES NO																																																																																									
28. TOTAL CHARGE \$ 130.00		29. AMOUNT PAID \$																																																																																									
30. BALANCE DUE \$ 130.00		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)																																																																																									
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Any Provider 12 Any Street Anytown, NC 12345 PRA 8300000F GRP# 8300000		34. PHYSICIAN OR SUPPLIER INFORMATION																																																																																									

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5/86) PLEASE PRINT OR TYPE APPROVED CMB-0338-0338 FORM CMB-1506 (12/96) FORM FRB-1500 APPROVED CMB-1215-0285 FORM QWCP-1506 APPROVED CMB-0723-0001 (CHAMPUS)

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Diagnostic Assessment
No Age Limitation

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LING (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999T	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.		3. PATIENT'S BIRTH DATE MM DD YY M F	
5. PATIENT'S ADDRESS (No., Street) 123 Any Street		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Any Town		7. INSURED'S ADDRESS (No., Street)	
STATE NC		CITY	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT?	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? PLACE (State) c. OTHER ACCIDENT?		11. INSURED'S POLICY GROUP OR FECA NUMBER	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.	
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
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19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)	
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23. PRIOR AUTHORIZATION NUMBER		24. TABLE	
24. TABLE		25. FEDERAL TAX I.D. NUMBER SSN EIN	
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 175 00	
28. TOTAL CHARGE \$ 175 00		29. AMOUNT PAID \$	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 175 00	
30. BALANCE DUE \$ 175 00		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) A. Provider 10/25/05	
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Intensive In-Home

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN PECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.
3. PATIENT'S BIRTH DATE MM DD YY 09 06 1990 M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial) 999999999T
5. PATIENT'S ADDRESS (No., Street) 123 Any Street
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS Single Married Other
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE
23. PRIOR AUTHORIZATION NUMBER
24. TABLE: DATE(S) OF SERVICE, PLACE OF SERVICE, TYPE OF SERVICE, PROCEDURES, SERVICES, OR SUPPLIES, DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EMG, COB, RESERVED FOR LOCAL USE
25. FEDERAL TAX I.D. NUMBER
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

Claim Form Examples

PLEASE
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AREA



Multisystemic Therapy (MST)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM									
<div style="display: flex; justify-content: space-between;"> 1. MEDICARE <input type="checkbox"/> (Medicare #) <input checked="" type="checkbox"/> 2. MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> 3. CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> 4. CHAMPVA <input type="checkbox"/> (VA File #) <input type="checkbox"/> 5. GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> 6. FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> 7. OTHER <input type="checkbox"/> (ID) <input type="checkbox"/> </div>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.				3. PATIENT'S BIRTH DATE MM DD YY 07 16 1986		4. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999T		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) 123 Any Street				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 Any Town		STATE NC		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE	
ZIP CODE 12345		TELEPHONE (Include Area Code) (919) 123-4567		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input checked="" type="checkbox"/>		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) <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		11. INSURED'S POLICY GROUP OR PEGA NUMBER			
d. OTHER INSURED'S POLICY OR GROUP NUMBER				10a. RESERVED FOR LOCAL USE		12. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		13. EMPLOYER'S NAME OR SCHOOL NAME	
d. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. EMPLOYER'S NAME OR SCHOOL NAME		e. INSURANCE PLAN NAME OR PROGRAM NAME		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete items 9 a-d.</i>			
g. INSURANCE PLAN NAME OR PROGRAM NAME				10b. RESERVED FOR LOCAL USE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM									
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.					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 _____					SIGNED _____				
DATE _____					DATE _____				
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 PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input 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)				23. PRIOR AUTHORIZATION NUMBER		24. F. \$ CHARGES G. DAYS EPBDT OR Family Plan H. EMG I. CDS J. RESERVED FOR LOCAL USE			
1. 290				3. _____		24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I. MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS EPBDT OR Family Plan H. EMG I. CDS J. RESERVED FOR LOCAL USE			
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For DRG, CASRL, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 100.00	
29. AMOUNT PAID \$				30. BALANCE DUE \$ 100.00		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this SR and are made a part thereof.) A. Provider 10/17/05			
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 12 Any Street Anytown, NC 12345 P# 8300000 G# 8300000					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/98) PLEASE PRINT OR TYPE APPROVED OMB-0305-0008 FORM CMS-1500 (12/96), FORM RRB-1550, APPROVED OMB-1215-0025 FORM GWCP-1595, APPROVED OMB-0703-0001 (CHAMPUS)

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Community Support Teams (CST)

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) PECA BLU/LUNG (SSN) OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) **999999999T**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Recipient, Jane, D.** 3. PATIENT'S BIRTH DATE (MM DD YY) **02 07 1978** SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) **123 Any Street** 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY **Any Town** STATE **NC** 8. PATIENT STATUS Single Married Other CITY STATE

ZIP CODE **12345** TELEPHONE (Include Area Code) **(919) 123-4567** 9. EMPLOYED Full-Time Part-Time Student ZIP CODE TELEPHONE (INCLUDE AREA CODE)

3. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR PECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M F

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX M F b. AUTO ACCIDENT? PLACE (State) YES NO b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, return to and complete item 9 a-d.

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. 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 _____ DATE _____ SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (M/F) 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 PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

1. **290** 3. _____ 23. PRIOR AUTHORIZATION NUMBER

24. A	B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE (From MM DD YY To MM DD YY)	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	ESPT Family Plan	EMG	GGP	RESERVED FOR LOCAL USE
10 20 05 10 20 05	12		H2015 HT		70 00	4				

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ **70 00** 29. AMOUNT PAID \$ 30. BALANCE DUE \$ **70 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.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

A. Provider 10/20/05
SIGNED _____ DATE _____

Any Provider
12 Any Street
Anytown NC 12345
P# 8300000 GPe 8300000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Examples

PLEASE
DO NOT
STAPLE
IN THIS
AREA



Assertive Community Treatment Team
(ACTT)

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #)	MEDICAID <input checked="" type="checkbox"/> (Medicaid #)	CHAMPUS <input type="checkbox"/> (Sponsor's SSN)	CHAMPVA <input type="checkbox"/> (VA File #)	GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)	FECA <input type="checkbox"/> (SSN)	OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.							3. PATIENT'S BIRTH DATE MM DD YY 05 29 1975	4. INSURED'S NAME (Last Name, First Name, Middle Initial) 999999999T
5. PATIENT'S ADDRESS (No., Street) 123 Any Street				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 Any Town		STATE NC	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	STATE		
ZIP CODE 12345		TELEPHONE (Include Area Code) (919) 123-4567		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP 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		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		c. EMPLOYER'S NAME OR SCHOOL NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME		12. INSURED'S DATE OF BIRTH MM DD YY		
c. EMPLOYER'S NAME OR SCHOOL NAME		100. RESERVED FOR LOCAL USE		e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
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.				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 _____ DATE _____				SIGNED _____				
14. DATE OF CURRENT ILLNESS (If first symptoms) 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 PHYSICIAN OR OTHER SOURCE		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. RESERVED FOR LOCAL USE		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
1. 290				23. PRIOR AUTHORIZATION NUMBER				
24. DATE(S) OF SERVICE FROM MM DD YY		A	B	C	D	E	F	
10 05 05		10 05 05	12	H0040			350 00	
25. FEDERAL TAX I.D. NUMBER		SSN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 350 00	29. AMOUNT PAID \$	30. BALANCE DUE \$ 350 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. A. Provider 10/5/05 SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 12 Any Street Anytown, NC 12345 PINF 8300000A GRP# 8300000				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Form Examples

PLEASE DO NOT STAPLE IN THIS AREA



Partial Hospital

CARRIER

HEALTH INSURANCE CLAIM FORM

<input type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PECA <input type="checkbox"/> OTHER		<input type="checkbox"/> PICA <input type="checkbox"/> PICA	
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN PECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (SNW) (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 999999999T	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Jane, D.		3. PATIENT'S BIRTH DATE MM DD YY 07 01 1998 M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 123 Any Street CITY: Any Town STATE: NC ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567		4. INSURED'S NAME (Last Name, First Name, Middle Initial) 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) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		6. PATIENT RELATIONSHIP TO INSURED Set <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> b. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input checked="" type="checkbox"/>	
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: DATE:		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10a. RESERVED FOR LOCAL USE	
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	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. 290 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A. DATES (S) OF SERVICE FROM MM DD YY TO MM DD YY B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS EPST OR UNITS H. Family Plan I. EMG J. COB K. RESERVED FOR LOCAL USE 1. 10 23 05 10 23 05 22 H0035 130 00 1			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For 25a, 25b, 25c, see book) YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. TOTAL CHARGE \$ 130 00 29. AMOUNT PAID \$ 30. BALANCE DUE \$ 130 00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) A. Provider 10/23/05 SIGNED DATE		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 12 Any Street Anytown, NC 12345 PHS# 83000000 GRP# 8300000	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Mark T. Benton

Mark T. Benton, Senior Deputy Director and
Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier

Cheryll Collier
Executive Director
EDS
