

# PERSONAL ATTENDANT SERVICE (PAS)

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LING <input checked="" type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (/SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER <b>123456789</b>															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>																			
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>				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) <b>123 ABC Street</b>																			
CITY <b>Anytown</b>		STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY <b>Anytown</b>		STATE <b>TX</b>															
ZIP CODE <b>77777</b>		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"/>		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"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				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		d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>															
10d. RESERVED FOR LOCAL USE		11. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 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 <b>SIGNATURE ON FILE</b> 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 <b>SIGNATURE ON FILE</b>																	
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? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>L 799.99</b>		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER																	
2.		3.		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C.		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Part		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
1		2		3		4		5		6		7		8		9		10		11		12			
02 01 07		02 15 07		12		SS125		U7		US		1		800 00		80		NPI		NPI		NPI			
2		3		4		5		6		7		8		9		10		11		12		13			
3		4		5		6		7		8		9		10		11		12		13		14			
4		5		6		7		8		9		10		11		12		13		14		15			
5		6		7		8		9		10		11		12		13		14		15		16			
6		7		8		9		10		11		12		13		14		15		16		17			
25. FEDERAL TAX I.D. NUMBER <b>123456789</b>		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>800.00</b>		29. AMOUNT PAID		30. BALANCE DUE \$ <b>800.00</b>		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.) SIGNATURE ON FILE											
SIGNED		DATE		32. SERVICE FACILITY LOCATION INFORMATION <b>ABC Home Health 123 Caring Street Anytown, TX 77777</b>		a. NPI		33. BILLING PROVIDER INFO & PH # (123) 456 7890 <b>ABC Home Health 123 Caring Street Anytown, TX 77777</b>		a. LTSS Number		b.													

RESPITE

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>										1a. INSURED'S I.D. NUMBER <b>123456789</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>												
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>					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) <b>123 ABC Street</b>												
CITY <b>Anytown</b>		STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY <b>Anytown</b>		STATE <b>TX</b>										
ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) <b>( )</b>			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) <b>( 123 ) 456 7890</b>										
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 SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										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 <b>SIGNATURE ON FILE</b> DATE										SIGNED <b>SIGNATURE ON FILE</b>									
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					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)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
1. <b>L 799.99</b>										23. PRIOR AUTHORIZATION NUMBER									
2.										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 F. \$ CHARGES G. DAYS OR UNITS H. EPOBT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 <b>02 01 07 02 15 07 12 S5151 U3 U3 1 800 00 80 NPI</b>																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX I.D. NUMBER <b>123456789</b>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>800 00</b>		29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>800 00</b>								
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.) <b>SIGNATURE ON FILE</b>					32. SERVICE FACILITY LOCATION INFORMATION <b>ABC Home Health 123 Caring Street Anytown, TX 77777</b>					33. BILLING PROVIDER INFO & PH # <b>( 123 ) 456 7890</b> <b>ABC Home Health 123 Caring Street Anytown, TX 77777</b>									
SIGNED DATE					a. <b>NPI</b>					a. <b>LTSS Number</b>									

# PROFESSIONAL SERVICES

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> (Medicare #)                    MEDICAID <input type="checkbox"/> (Medicaid #)                    TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)                    CHAMPVA <input type="checkbox"/> (Member ID#)                    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 123456789	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John M.				3. PATIENT'S BIRTH DATE MM DD YY    SEX 01 01 1900 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John M.					
5. PATIENT'S ADDRESS (No., Street) 123 ABC 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) 123 ABC Street					
CITY Anytown		STATE TX		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY Anytown		STATE TX			
ZIP CODE 77777		TELEPHONE (Include Area Code) ( )		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE 77777		TELEPHONE (Include Area Code) (123) 456 7890			
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    SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO    PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME HMO NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    If yes, return to and complete item 9 a-d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE   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   authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED _____ DATE _____ SIGNATURE ON FILE					SIGNED _____ DATE _____ SIGNATURE ON FILE						
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. 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					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. L 799.99			3.			23. PRIOR AUTHORIZATION NUMBER					
2.			4.			24. A. DATE(S) OF SERVICE    B. PLACE OF SERVICE    C. EMG    D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)    E. DIAGNOSIS POINTER    F. \$ CHARGES    G. DAYS OR UNITS    H. EPST Family Plan    I. ID. QUAL.    J. RENDERING PROVIDER ID. #					
02 01 07   02 08 07   12			S9123			800 00   8					
1			1			NPI					
2			1			NPI					
3			1			NPI					
4			1			NPI					
5			1			NPI					
6			1			NPI					
25. FEDERAL TAX I.D. NUMBER 123456789			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 800 00		29. AMOUNT PAID \$	30. BALANCE DUE \$ 800 90	
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.) SIGNATURE ON FILE			32. SERVICE FACILITY LOCATION INFORMATION ABC Home Health 123 Caring Street Anytown, TX 77777			33. BILLING PROVIDER INFO & PH # (123) 456 7890					
SIGNED _____ DATE _____			a. NPI			a. LTSS Number					

# DAY ACTIVITY AND HEALTH SERVICE (DAHS)

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER <b>123456789</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>				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) <b>123 ABC Street</b>					
CITY <b>Anytown</b>		STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY <b>Anytown</b>		STATE <b>TX</b>			
ZIP CODE <b>77777</b>		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		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"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State)		a. INSURED'S DATE OF BIRTH MM DD YY			
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 <b>HMO NAME</b>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, return to and complete item 9 a-d.			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		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 <b>SIGNATURE ON FILE</b> 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 <b>SIGNATURE ON FILE</b>		11. INSURED'S DATE OF BIRTH MM DD YY			
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		b. EMPLOYER'S NAME OR SCHOOL NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.		17b. NPI		b. EMPLOYER'S NAME OR SCHOOL NAME			
19. RESERVED FOR LOCAL USE				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. <b>L 799.99</b>				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
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	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan		
1 <b>02 01 07 02 15 07 99</b>		S5101	330 00	22	NPI	NPI	NPI	NPI			
2		NPI	NPI	NPI	NPI	NPI	NPI	NPI			
3		NPI	NPI	NPI	NPI	NPI	NPI	NPI			
4		NPI	NPI	NPI	NPI	NPI	NPI	NPI			
5		NPI	NPI	NPI	NPI	NPI	NPI	NPI			
6		NPI	NPI	NPI	NPI	NPI	NPI	NPI			
25. FEDERAL TAX I.D. NUMBER <b>123456789</b>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>330 00</b>		29. AMOUNT PAID \$			
30. BALANCE DUE \$ <b>330 00</b>		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.) <b>SIGNATURE ON FILE</b>		32. SERVICE FACILITY LOCATION INFORMATION <b>ABC DAHS 123 Activity Street Anytown, TX 77777</b>		33. BILLING PROVIDER INFO & PH # <b>ABC DAHS 123 Activity Street Anytown, TX 77777</b>		(123) 456 7890			
SIGNED DATE		a. NPI		a. LTSS Number		NPI		NPI			

# ADULT FOSTER CARE (AFC)

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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/LING <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER 123456789	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John M.					3. PATIENT'S BIRTH DATE MM DD YY 01 01 1900 M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, John M.				
5. PATIENT'S ADDRESS (No., Street) 123 ABC Street CITY: Anytown STATE: TX ZIP CODE: 77777 TELEPHONE: ( )					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) 123 ABC Street CITY: Anytown STATE: TX ZIP CODE: 77777 TELEPHONE: (123) 456 7890				
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 M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					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		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME HMO NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 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: SIGNATURE ON FILE 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: SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 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? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. L 799.99 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 C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #											
1   02   01   07   02   15   07   12   S5140   199   U3   1   800.00   15   NPI											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN 123456789			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 800.00		29. AMOUNT PAID \$	30. BALANCE DUE \$ 800.00	
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.) SIGNATURE ON FILE			32. SERVICE FACILITY LOCATION INFORMATION ABC AFC Home 123 Caring Street Anytown, TX 77777			33. BILLING PROVIDER INFO & PH # (123) 456 7890 ABC AFC Home 123 Caring Street Anytown, TX 77777					
SIGNED: DATE:			a. NPI		a. LTSS Number						

# ADULT FOSTER CARE - RESPITE

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <span style="float: right;">PICA</span>																							
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BOX LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>123456789</b>																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>																
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>					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) <b>123 ABC Street</b>																
CITY <b>Anytown</b>			STATE <b>TX</b>		CITY <b>Anytown</b>			STATE <b>TX</b>															
ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) ( )			ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) (123) 456 7890																
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 SEX <input type="checkbox"/> M <input type="checkbox"/> F													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME													
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>													
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 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.										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 <b>SIGNATURE ON FILE</b> DATE					SIGNED <b>SIGNATURE ON FILE</b> 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 PROVIDER OR OTHER SOURCE					17a. NPI					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. <b>L 799.99</b>										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		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSON Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 <b>02 01 07 02 15 07 12</b>					<b>SS1511</b>		<b>199 U3</b>			<b>1</b>		<b>800.00 15</b>		<b>NPI</b>									
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX ID. NUMBER <b>123456789</b>					SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>800.00</b>		29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>800.00</b>							
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.) <b>SIGNATURE ON FILE</b>					32. SERVICE FACILITY LOCATION INFORMATION <b>ABC AFC Home 123 Caring Street Anytown, TX 77777</b>					33. BILLING PROVIDER INFO & PH # (123) 456 7890 <b>ABC AFC Home 123 Caring Street Anytown, TX 77777</b>													
SIGNED DATE					a. <b>NPI</b>					a. <b>LTSS Number</b>													

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# ASSISTED LIVING (AL)

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										PICA <input type="checkbox"/>	
1a. INSURED'S I.D. NUMBER <b>123456789</b>										(For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b>			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>	
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>					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) <b>123 ABC Street</b>			
CITY <b>Anytown</b>			STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY <b>Anytown</b>		STATE <b>TX</b>	
ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) ( )			Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) (123) 456 7890		
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		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? <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 <b>HMO NAME</b>			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, return to and complete item 9 a-d.	
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 <b>SIGNATURE ON FILE</b> DATE						SIGNED <b>SIGNATURE ON FILE</b>					
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			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a.			17b. NPI		
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. <b>L 799.99</b>						22. MEDICAID RESUBMISSION CODE			ORIGINAL REF. NO.		
2.						23. PRIOR AUTHORIZATION NUMBER					
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		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 <b>02 01 07 02 15 07 13</b>		<b>T2031</b>		<b>99 U8 U1 U1 1</b>		<b>750 00</b>		<b>15</b>		<b>NPI</b>	
2		3		4		5		6		NPI	
3		4		5		6		7		NPI	
4		5		6		7		8		NPI	
5		6		7		8		9		NPI	
6		7		8		9		10		NPI	
25. FEDERAL TAX I.D. NUMBER <b>123456789</b>		SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>750 00</b>		29. AMOUNT PAID \$ <b>750 00</b>	
30. BALANCE DUE \$ <b>750 00</b>		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.) <b>SIGNATURE ON FILE</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>ABC Assisted Living 123 Caring Street Anytown, TX 77777</b>			
SIGNED DATE		a. NPI		b.		33. BILLING PROVIDER INFO & PH # <b>ABC Assisted Living 123 Caring Street Anytown, TX 77777</b>		a. <b>LTSS Number</b>			

# ASSISTED LIVING - RESPITE

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA										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 LING <input type="checkbox"/> OTHER <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER <b>123456789</b>					(For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>																			
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>					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) <b>123 ABC Street</b>																			
CITY <b>Anytown</b>			STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY <b>Anytown</b>			STATE <b>TX</b>																		
ZIP CODE <b>77777</b>			TELEPHONE (Include Area Code) ( )		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE <b>77777</b>			TELEPHONE (Include Area Code) ( 123 ) 456 7890																		
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"/> SEX																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> SEX					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										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.										SIGNED <b>SIGNATURE ON FILE</b> 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 PROVIDER OR OTHER SOURCE					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					17b. NPI					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)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
1. <b>L 799.99</b>										23. PRIOR AUTHORIZATION NUMBER																			
2.										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 F. \$ CHARGES G. DAYS OR UNITS H. EPSON (Family Plan) I. ID. QUAL J. RENDERING PROVIDER ID. #																			
3.										1 <b>02 01 07 02 15 07 13 S5151 99 U8 U1 U1 1 750 00 15 NPI</b>																			
4.										2 <b>NPI</b>																			
5.										3 <b>NPI</b>																			
6.										4 <b>NPI</b>																			
7.										5 <b>NPI</b>																			
8.										6 <b>NPI</b>																			
25. FEDERAL TAX I.D. NUMBER <b>123456789</b> SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ <b>750 00</b>					29. AMOUNT PAID \$					30. BALANCE DUE \$ <b>750 00</b>				
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.) <b>SIGNATURE ON FILE</b>										32. SERVICE FACILITY LOCATION INFORMATION <b>ABC Assisted Living 123 Caring Street Anytown, TX 77777</b>										33. BILLING PROVIDER INFO & PH # <b>ABC Assisted Living 123 Caring Street Anytown, TX 77777</b>									
SIGNED DATE										a. <b>NPI</b>										a. <b>LTSS Number</b>									

# MINOR HOME MODIFICATION

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>									
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 BKTLING (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>123456789</b>				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>		
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>					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) <b>123 ABC Street</b>		
CITY <b>Anytown</b>		STATE <b>TX</b>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY <b>Anytown</b>		STATE <b>TX</b>	
ZIP CODE <b>77777</b>		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? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 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"/>		c. EMPLOYER'S NAME OR SCHOOL NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		b. EMPLOYER'S NAME OR SCHOOL NAME <b>HMO NAME</b>	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>	
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 <b>SIGNATURE ON FILE</b> 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 <b>SIGNATURE ON FILE</b>									
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. <input type="checkbox"/> 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? \$ 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. <b>L799.99</b>			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. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSON Family Plan I. J.D. QUAL J. RENDERING PROVIDER ID.#			
1 <b>02 01 07 02 01 07 12 S5165 1 250 00</b>			2 _____			25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ <b>250 00</b> 29. AMOUNT PAID \$ 30. BALANCE DUE \$ <b>250 00</b>			
3 _____			4 _____			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.) <b>SIGNATURE ON FILE</b>			
4 _____			5 _____			32. SERVICE FACILITY LOCATION INFORMATION <b>ABC Construction 123 Builder Street Anytown, TX 77777</b>			
5 _____			6 _____			33. BILLING PROVIDER INFO & PH # ( 123 ) 456 7890 <b>ABC Construction 123 Builder Street Anytown, TX 77777</b>			
6 _____			a. NPI			a. LTSS Number			

# EMERGENCY RESPONSE

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BUX (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER <b>123456789</b> (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>		3. PATIENT'S BIRTH DATE MM DD YY SEX <b>01 01 1900 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>		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) <b>123 ABC Street</b>		8. 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 type="checkbox"/>	
CITY <b>Anytown</b> STATE <b>TX</b>		CITY <b>Anytown</b> STATE <b>TX</b>	
ZIP CODE <b>77777</b> TELEPHONE (Include Area Code) <b>( )</b>		ZIP CODE <b>77777</b> TELEPHONE (Include Area Code) <b>( 123 ) 456 7890</b>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER <b>HMO NAME</b>		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input 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 <b>SIGNATURE ON FILE</b> 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 <b>SIGNATURE ON FILE</b>	
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 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 (Retain Items 1, 2, 3 or 4 to Item 24E by Line)		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
1. <b>L 799.99</b>		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
2.		23. PRIOR AUTHORIZATION NUMBER	
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		F. \$ CHARGES	
G. DAYS OR UNITS		H. EPOSD Family Plan	
I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 <b>02 01 07 02 28 07 12 S5161 I 40 00</b>		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER <b>123456789</b> SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>40 00</b>	
29. AMOUNT PAID \$		30. BALANCE DUE \$ <b>40 00</b>	
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 <b>SIGNATURE ON FILE</b> DATE		32. SERVICE FACILITY LOCATION INFORMATION <b>ABC ERS</b> <b>123 Help Street</b> <b>Anytown, TX 77777</b>	
33. BILLING PROVIDER INFO & PH # <b>( 123 ) 456 7890</b>		a. LTSS Number	

# HOME DELIVERED MEALS

**1500**

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

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"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										PICA <input type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>			3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1900</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER <b>123456789</b>					
5. PATIENT'S ADDRESS (No., Street) <b>123 ABC Street</b>			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>Doe, John M.</b>					
CITY <b>Anytown</b>		STATE <b>TX</b>	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY <b>Anytown</b>		STATE <b>TX</b>			
ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) ( )			ZIP CODE <b>77777</b>		TELEPHONE (Include Area Code) ( 123 ) 456 7890				
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"/>			7. INSURED'S ADDRESS (No., Street) <b>123 ABC Street</b>					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME <b>HMO NAME</b>					
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. SIGNED <u>SIGNATURE ON FILE</u> 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 <u>SIGNATURE ON FILE</u>						
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											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <u>L 799.99</u>					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES						
2. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
3. _____					23. PRIOR AUTHORIZATION NUMBER						
4. _____					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/HCP/PCS I MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ESPT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #						
1 <b>02 01 07 02 28 07 12 S5170 1 200 00 28 NPI</b>											
2 _____ NPI											
3 _____ NPI											
4 _____ NPI											
5 _____ NPI											
6 _____ NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ <b>200 00</b>		29. AMOUNT PAID \$	30. BALANCE DUE \$	
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.) <b>SIGNATURE ON FILE</b> SIGNED _____ DATE _____			32. SERVICE FACILITY LOCATION INFORMATION <b>ABC ERS                  123 Eat Street                  Anytown, TX 77777</b>			33. BILLING PROVIDER INFO & PH # ( 123 ) 456 7890 <b>ABC Meals on Wheels                  123 Eat Street                  Anytown, TX 77777</b>					
a. NPI			a. LTSS Number								