

# Durable Medical Equipment Billing Guidelines

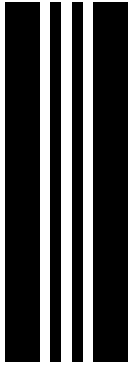
**MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM**

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

CODE  
A V

ORIGINAL CLAIM REFERENCE NUMBER

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**



DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last) <b>JANE SMITH</b>		2. DATE OF BIRTH <b>05/20/1990</b>		2A. TOTAL ANNUAL FAMILY INCOME		4. INSURED'S NAME (First name, middle initial, last name)							
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)				5. INSURED'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		5A. PATIENT'S SEX MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		6. MEDICARE NUMBER			6A. MEDICAID NUMBER <b>A B 1 2 3 4 5 C</b>		
				5B. PATIENT'S TELEPHONE NUMBER		6B. PRIVATE INSURANCE NUMBER			GROUP NO.		RECIPROCIITY NO.		
6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL				7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>				8. INSURED'S EMPLOYER OR OCCUPATION					
9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number				10. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT <input checked="" type="checkbox"/> CRIME VICTIM <input checked="" type="checkbox"/> AUTO ACCIDENT <input checked="" type="checkbox"/> OTHER LIABILITY <input checked="" type="checkbox"/>				11. INSURED'S ADDRESS (Street, City, State, Zip Code)					
12. PATIENT'S OR AUTHORIZED SIGNATURE				DATE MM DD YY		13. INSURED'S SIGNATURE							

**PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)**

14. DATE OF ONSET OF CONDITION MM DD YY		15. FIRST CONSULTED FOR CONDITION MM DD YY		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS YES <input type="checkbox"/> NO <input type="checkbox"/>		16A. EMERGENCY RELATED YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		17. DATE PATIENT MAY RETURN TO WORK MM DD YY		18. DATES OF DISABILITY TOTAL <input type="checkbox"/> PARTIAL <input type="checkbox"/>		FROM MM DD YY		TO MM DD YY									
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>Peter Smith</b>				19A. ADDRESS (OR SIGNATURE SHF ONLY)				19B. PROF CD		19C. IDENTIFICATION NUMBER <b>0 1 2 3 4 5 6 7</b>				19D. DX CODE									
20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES		ADMITTED MM DD YY		DISCHARGED MM DD YY		20A. NAME OF HOSPITAL				20B. SURGERY DATE MM DD YY		20C. TYPE OF SURGERY											
21. NAME OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				21A. ADDRESS OF FACILITY				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES <input type="checkbox"/> NO <input type="checkbox"/>				LAB CHARGES											
22A. SERVICE PROVIDER NAME				22B. PROF CD		22C. IDENTIFICATION NUMBER		22D. STERILIZATION ABORTION CODE		22E. STATUS CODE													
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24H BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE								22F. POSSIBLE DISABILITY <input checked="" type="checkbox"/> N		22G. EPSDT C/THP <input type="checkbox"/> N		22H. FAMILY PLANNING <input type="checkbox"/> N		23A. PRIOR APPROVAL NUMBER		23B. PAYMT SOURCE CODE <b>1 1</b>							
24A. DATE OF SERVICE M M D D Y Y		24B. PLACE		24C. PROCEDURE CD		24D. MOD		24E. MOD		24F. MOD		24G. MOD		24H. DIAGNOSIS CODE		24I. DAYS OR UNITS		24J. CHARGES		24K.		24L.	
<b>0 3 2 8 0 5</b>		<b>1 1</b>		<b>K 0 0 0 1</b>		<b>R R</b>								<b>8 9 7 0</b>				<b>7 2 0 0</b>					
<b>0 3 2 8 0 5</b>		<b>1 1</b>		<b>E 0 2 7 5</b>										<b>7 8 6 2</b>				<b>3 7 8</b>					
24M. INPATIENT HOSPITAL VISITS		FROM MM DD YY		THROUGH MM DD YY		24N. PROC CD		24O. MOD															
25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF) <b>James Strong</b> SIGNATURE OF PHYSICIAN OR SUPPLIER								26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>				27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE							
25A. PROVIDER IDENTIFICATION NUMBER <b>0 1 2 3 4 5 6 7</b>								30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER				31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE <b>ABC Health Supplies 312 Main Street Anytown, New York 11111</b>											
25B. MEDICAID GROUP IDENTIFICATION NUMBER				25C. LOCATOR CODE <b>0 0 3</b>		25D. SA EXCP CODE		32A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>				TELEPHONE NUMBER ( ) EXT.											
COUNTY OF SUBMITTAL		25E. DATE SIGNED <b>04 06 05</b>		32. PATIENT'S ACCOUNT NUMBER				A B C 1 2 3 4 5				DO NOT WRITE IN THIS SPACE											
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER				34. PROF CD		35. CASE MANAGER ID																	