Physician 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)*	2. DATE OF BIRTH	2A. TOTAL ANNUAL FAMILY INCOME	4. INSURED'S NAME *(First name, middle initial, last name)*
JANE SMITH	05 20 1990		

4. PATIENT'S ADDRESS *(Street, City, State, Zip Code)*	5. INSURED'S SEX MALE / FEMALE	5A. PATIENT'S SEX MALE / FEMALE	6. MEDICARE NUMBER	6A. MEDICAID NUMBER
		X / X		AB12345C

5B. PATIENT'S TELEPHONE NUMBER	6B. PRIVATE INSURANCE NUMBER	GROUP NO.	RECIPROCITY NO.
( )			

6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL	7. PATIENT'S RELATIONSHIP TO INSURED SELF / SPOUSE / CHILD / OTHER	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	11. INSURED'S ADDRESS (Street, City, State, Zip Code)
	PATIENT'S EMPLOYMENT: X — CRIME VICTIM: X AUTO ACCIDENT: X — OTHER LIABILITY: X	

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	16A. EMERGENCY RELATED	17. DATE PATIENT MAY RETURN TO WORK MM DD YY	18. DATES OF DISABILITY TOTAL / PARTIAL — FROM MM DD YY — TO MM DD YY
		YES / NO	YES X / X NO		

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	19A. ADDRESS *(OR SIGNATURE SHF ONLY)*	19B. PROF CD	19C. IDENTIFICATION NUMBER	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 / NO	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 ▼

1.
2.
3.

22F. POSSIBLE DISABILITY	22G. EPSDT C/THP	22H. FAMILY PLANNING
Y X	Y N	Y X

23A. PRIOR APPROVAL NUMBER	23B. PAYM'T SOURCE CODE
	1 1

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.
04 04 05	11	99205					78 6.2		30.00		
04 04 05	11	93000					78 6.2		15.00		
04 11 05	11	99213					78 6.2		30.00		

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)	26. ACCEPT ASSIGNMENT YES / NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
James Strong SIGNATURE OF PHYSICIAN OR SUPPLIER	30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE		
		James Strong, M.D. 312 Main Street Anytown, New York 11111		

25A. PROVIDER IDENTIFICATION NUMBER				
01234567				

25B. MEDICAID GROUP IDENTIFICATION NUMBER	25C. LOCATOR CODE	25D. SA EXCP CODE	32A. MY FEE HAS BEEN PAID YES / NO	TELEPHONE NUMBER ( ) EXT.
	003			

COUNTY OF SUBMITTAL	25E. DATE SIGNED	32. PATIENT'S ACCOUNT NUMBER	DO NOT WRITE IN THIS SPACE
	04 15 05	ABC12345	

33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER	34. PROF CD	35. CASE MANAGER ID

EMEDNY – 150001 ((1/04)