Podiatry 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

DO NOT STAPLE IN BARCODE AREA

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First, middle, last): JANE SMITH	2. DATE OF BIRTH: 05 20 1990	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 ☐ FEMALE ☐	5A. PATIENT'S SEX: MALE X FEMALE X	6. MEDICARE NUMBER / 6A. MEDICAID NUMBER: 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: PATIENT'S EMPLOYMENT X / CRIME VICTIM X; AUTO ACCIDENT X / OTHER LIABILITY X		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 ☐ NO ☐	16A. EMERGENCY RELATED: YES X NO X	17. DATE PATIENT MAY RETURN TO WORK MM DD YY	18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM MM DD YY	TO MM DD YY
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: 1M 1O

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	DAYS OR UNITS	24J. CHARGES	24K.	24L.
03 23 05	11	99202					686.9		50.00		
03 23 05	11	10060					686.9		80.00		
04 04 05	11	99212					686.9		50.00		

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)

James Strong

SIGNATURE OF PHYSICIAN OR SUPPLIER

26. ACCEPT ASSIGNMENT: YES ☐ NO ☐

27. TOTAL CHARGE — 28. AMOUNT PAID — 29. BALANCE DUE

30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE

James Strong, D.P.M.
312 Main Street
Anytown, New York 11111

TELEPHONE NUMBER ( ) EXT.

25A. PROVIDER IDENTIFICATION NUMBER: 01234567

25B. MEDICAID GROUP IDENTIFICATION NUMBER

25C. LOCATOR CODE: 003 — 25D. SA EXCP CODE — 32A. MY FEE HAS BEEN PAID: YES ☐ NO ☐

COUNTY OF SUBMITTAL — 25E. DATE SIGNED: 04 04 05 — 32. PATIENT'S ACCOUNT NUMBER: ABC12345

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

DO NOT WRITE IN THIS SPACE

EMEDNY – 150001 ((1/04)