

Podiatry Billing Guidelines

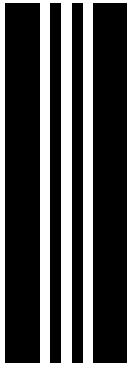
MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

ONLY TO BE USED TO ADJUST/VOID PAID CLAIM

CODE
A V

ORIGINAL CLAIM REFERENCE NUMBER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION



DO NOT STAPLE IN BARCODE AREA

1. PATIENT'S NAME (First, middle, last) JANE SMITH		2. DATE OF BIRTH 05 20 19 90		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 checked="" type="checkbox"/>		5A. PATIENT'S SEX MALE <input checked="" type="checkbox"/> FEMALE <input checked="" type="checkbox"/>		6. MEDICARE NUMBER			6A. MEDICAID NUMBER A B 1 2 3 4 5 C		
6. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL		5B. PATIENT'S TELEPHONE NUMBER		6B. PRIVATE INSURANCE NUMBER		GROUP NO.			RECIPROCIITY NO.		
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				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 <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 Y <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/>		22G. EPSDT C/THP Y <input type="checkbox"/> N <input type="checkbox"/>		22H. FAMILY PLANNING Y <input type="checkbox"/> X <input checked="" type="checkbox"/>		23A. PRIOR APPROVAL NUMBER		23B. PAYMT SOURCE CODE 1M 10	
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.	
0 3 2 3 0 5		1 1	9 9 2 0 2						6 8 6.9			5.0 0					
0 3 2 3 0 5		1 1	1 0 0 6 0						6 8 6.9			8.0 0					
0 4 0 4 0 5		1 1	9 9 2 1 2						6 8 6.9			5.0 0					
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 <input type="checkbox"/> NO <input type="checkbox"/>				27. TOTAL CHARGE				28. AMOUNT PAID		29. BALANCE DUE			
25A. PROVIDER IDENTIFICATION NUMBER 0 1 2 3 4 5 6 7				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.					
25B. MEDICAID GROUP IDENTIFICATION NUMBER				25C. LOCATOR CODE 0 0 3		25D. SA EXCP CODE		32A. MY FEE HAS BEEN PAID YES <input type="checkbox"/> NO <input type="checkbox"/>		DO NOT WRITE IN THIS SPACE				EMEDNY - 150001 (1/04)			
COUNTRY OF SUBMITTAL		25E. DATE SIGNED 04 04 05		32. PATIENT'S ACCOUNT NUMBER		A B C 1 2 3 4 5											
33. OTHER REFERRING ORDERING PROVIDER ID/LICENSE NUMBER				34. PROF CD		35. CASE MANAGER ID											