Chiropractor Billing Guidelines

MEDICAL ASSISTANCE HEALTH INSURANCE			IO BE	CODE		ORIGINAL CLAIM REFERENCE NUMBER				
CLAIM FORM TITLE XIX PROGRAM			TO ST/VOID A	V						
PATIENT AND INSURED	PAID	CLAIM								
	PATIENT'S NAME (First, middle, last)	2. DATE OF BIR	RTH ZA.	TOTAL ANNUAL AMILY INCOME	4. INSURED'S N	AME (First name, middle initial, las	t name)			
			2 0 1 9 9 0							
DOT	MA		E FEMALE MALE FEMALE X			GA. MEDICAID NUMBER				
NOT 8										
STAPLE		()) PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER							
₹	6 C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL					8. INSURED'S EMPLOYER OR OCCUPATION				
BARO	9. OTHER HEALTH INSURANCE COVERAGE – Enter na	me 10 WAS COND	D. WAS CONDITION RELATED TO 11 PATIENTS X X CRIME VICTIM			11. INSURED'S ADDRESS (Street, City, State, Zip Code)				
BARCODE	of Policy Holder, Plan Name and Address, and Policy or P Insurance Number	ivate PATIENT'S								
AREA			ALITO OTHER							
		ACCIDEN'	CCIDENT X LIABILITY							
	12.		DATE		13.					
PATIENTS OR AUTHORIZED SIGNATURE MM DD YY INSURED'S SIGNATURE PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)										
	ONSULTED 16. HAS PATIENT EVER HAD SAN OR SIMILAR SYMPTOMS		Y 17. DA	TE PATIENT MAY TURN TO WORK	18. DATES OF D	ISABILITY FROM	oldining)	TO		
	DD YY YES N		X NO MM	DD YY	TOTAL	PARTIAL MM	DD YY	MM DD	YY	
19. NAME OF REFERRING PHYSICIAN OR	OTHER SOURCE	19A. ADDRESS (C	OR SIGNATURE SHF C	NLY)	19B. PROF CD	19C. IDENTIFICATION NUMBE	R	19D. DX CODE	•	
20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE	20A. NAME OF HO	OF HOSPITAL 20B. SURGERY DATE 20C. TYPE OF SURGERY								
HOSPITIALIZATION DATES MM 21. NAME OF FACILITY WHERE SERVICES	DD YY MM DD Y	Y 21A. ADDRESS O	MM DD YY							
21. NAME OF FACILITY WHERE SERVICES	S OF FACILITY 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE LAB CHARGES OUTSIDE YOUR OFFICE									
YES NO										
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. 22G. 22H.										
1.		•	POSSIBLE DISABILITY	X EPSDT C/THP	YN	FAMILY PLANNING	Х			
2. 3.			_	23A. PRIOR APPROV	OVAL NUMBER 23B. PAYM'T SOURCE CODE					
24A. 24B	. 24C. 24D. 24E.	24F. 24G. 24H		241. 2	4J.	24K.		2/ 10		
DATE OF PLA			DIAGNOSIS CODE	DAYS OR	CHARGI			24L.		
M M D D Y Y				UNITS						
0 4 0 4 0 5 1	1 9 8 9 4 0	8	3 9.2		<u> </u>	2 4.0 0	1 9.2 0	1 1 1 1	•	
0 4 0 7 0 5 1	1 9 8 9 4 0 1	8	3 9.2			2 4.0 0	1 9.2 0		.	
0 4 1 4 0 5 1	1 9 8 9 4 0 1	8	3 9 • 2			2 4.0 0	1 9.2 0		•	
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		240.MOD	•			1 • 1 1 1	•		·	
24M. FROM INPATIENT HOSPITAL VISITS MM DD	•				•		•			
25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON	26.	26. ACCEPT ASSIGNTMENT YES NO			27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE	DUE		
James Str		30. EMPLOYER IDENTIFICATION NUMBER/ SOCIAL SECURITY NUMBER			31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE					
SIGNATURE OF PHYSICIAN OR SUPPLIER					James Stror	ng				
25A. PROVIDER IDENTIFICATION NUMBER					312 Main Street					
0 1 2		OED CA 224 MYEEE HAD DEEN DAID			Anytown, New York 11111					
25B. MEDICAID GROUP IDENTIFICATION I	CODE EXCF	25D. SA SACP CODE YES 25D. NO NO			TELEPHONE NUMBER ()	EXT.			
COUNTY OF SUBMITTAL 25E. DATE S	0 3				DO NOT WRITE IN THIS SPA	CF	EMEDNY -	150001 ((1/04)		
04 1	B C 1 2	3 4 5	DO NOT WINTE IN THIS SPA	~ <u>_</u>		" "				
33. OTHER REFERRING ORDERING PROVID ID/LICENSE NUMBER	DER 34. PROF CD	35. CASE MA	ALL CONTROL OF THE CO							