Sample Enviromental Modification Claim Form

1. MEDICARE (Medicare #) | MEDICAID [x] (Medicaid #) | CHAMPUS (Sponsor's SSN) | CAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED I.D. NUMBER (for program in item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | Gender FEMALE

4. INSURED NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

7. INSURER'S ADDRESS (No. Street)

CITY

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURANCE'S NAME (Last Name, First Name, Middle Initial

a. OTHER INSURED'S POLICY OR GROPU NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | GENDER M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] [ ]

b. AUTO ACCIDENT? PLACE (State [ ] YES [ ] NO

c. OTHER ACCIENT? [ ] YES [ ] NO

10d. RESERVED FOR LOCAL USE

11. INSURER'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY | GENDER M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] Yes [ ] No If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED | DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. Give First Date MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | MM DD YY

19. RESERVED FOR LOCAL USE.

20. OUTSIDE LAB? [ ] Yes [ ] No | $ charges

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24 BY LINE)

1. Z73.6 | 3.

2. | 4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE FROM MM DD YY	TO MM DD YY	B	C Place Service	D PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G HOURS	H EPSDT Plan	I EMG	J COB	K RESERVED FOR
			12	S5165		Z73.6						
			12	S5165								
			12	S5165								
			12	S5165								
			12	S5165								
			12	S5165								

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] Yes [ ] No

28. TOTAL CHARGES $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)

SIGNED | Provider Signs & Dates | DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Name: _____

33. PROVIDER INFORMATION

ADDRESS:

CITY:

STATE: ZIP:

PHONE #

Sample