PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): INS123456

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

3. PATIENT'S BIRTH DATE (MM DD YY): 02/14/1985 | SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): John Doe

5. PATIENT'S ADDRESS (No., Street): 456 Elm St, Apt 23

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): 123 Main St, Apt 4B

CITY: Los Angeles | STATE: CA

8. PATIENT STATUS: Single (X) Married ( ) Other ( )

CITY: New York | STATE: NY

ZIP CODE: 90001 | TELEPHONE (Include Area Code): (555)123-4567

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: 10001 | TELEPHONE (INCLUDE AREA CODE): (123)456-7890

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): Mike Johnson

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: POL987654

a. OTHER INSURED'S POLICY OR GROUP NUMBER: G123456789

a. EMPLOYMENT? (CURRENT OR PREVIOUS): (X) YES ( ) NO

a. INSURED'S DATE OF BIRTH (MM DD YY): 03/15/1980 | SEX: M (X) F ( )

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): 06/10/1978 | SEX: M (X) F ( )

b. AUTO ACCIDENT? ( ) YES ( ) NO | PLACE (State): CA

b. EMPLOYER'S NAME OR SCHOOL NAME: ABC Corporation

c. EMPLOYER'S NAME OR SCHOOL NAME: ABC Corporation

c. OTHER ACCIDENT? ( ) YES ( ) NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ Health Plan

d. INSURANCE PLAN NAME OR PROGRAM NAME: XYZ Health Plan

10d. RESERVED FOR LOCAL USE: N/A

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (X) 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: Jane Doe | DATE: 10/2/2024

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: John Doe

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY): 01/20/2024

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE (MM DD YY): 12/01/2023

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY): FROM 01/20/2024 TO 02/05/2024

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Dr. John Smith

17a. I.D. NUMBER OF REFERRING PHYSICIAN: RP123456

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY): FROM 01/25/2024 TO 02/02/2024

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? (X) YES ( ) NO | $ CHARGES: $250

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

1. J11.1
2. E11.9
3. I10
4. M54.5

22. MEDICAID RESUBMISSION CODE: 07 | ORIGINAL REF. NO.: OR987654

23. PRIOR AUTHORIZATION NUMBER: PA123456

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
02/01/2024	02/10/2024	2	3	99214		J11.1	$250	1	No	No	No	N/A
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER: 98-7654321 | SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.: ACCT-12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO

28. TOTAL CHARGE: $1500

29. AMOUNT PAID: $200

30. BALANCE DUE: $1300

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: Dr. Emily Brown | DATE: 02/10/2024

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office): HealthCare Center, 123 Wellness St

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Dr. Emily Brown, MD

PIN#: 567890 | GRP#: G12345

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90) FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

X INS123456
Jane Doe 02/14/1985 X John Doe
456 Elm St, Apt 23 X 123 Main St, Apt 4B
Los Angeles CA X New York NY

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

90001 555-123-4567 10001 123 456-7890

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

Mike Johnson POL987654

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

G123456789 X 03/15/1980 X

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

06/10/1978 X CA ABC Corporation

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

ABC Corporation XYZ Health Plan

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

XYZ Health Plan N/A X

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

Jane Doe 10/23/2024 John Doe

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

01/20/2024 12/01/2023 01/20/2024 02/05/2024

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

Dr. John Smith RP123456 01/25/2024 02/02/2024

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

X $250

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

J11.1 I10 07 OR987654

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

E11.9 M54.5 PA123456

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

02/01/2024 02/10/2024 2 3 99214 J11.1 $250 1 No No No N/A

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

98-7654321 ACCT-12345 X $1500 $200 $1300

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

02/10/2024 HealthCare Center, 123 Wellness St Dr. Emily Brown, MD

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Dr. Emily Brown 567890 G12345