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PATIENT AND INSURED INFORMATION

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

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

680 REFERS TO GOVERNMENT PROGRAMS ONLY

660 MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process
640 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
620 authorizes any entity to release to Medicare medical and nonmedical information, including employment status, for the person has employer group health
600 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
580 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
560 CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge,
540 and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge
520 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
500 a mechanism for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those
480 items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

460 Los Angeles CA BLACK LUNG AND FECA CLAIMS

440 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
420 diagnosis coding systems.

400 SIGNED BY PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

380 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
360 incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS
340 regulations.

320 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
300 by me or my 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
280 offices, and 4) the services of nonphysicians must be included on the physician's bills.

260 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
240 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,
220 I further certify that the services performed were for a Black Lung-related disorder.

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

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

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

100 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
80 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
60 44 USC 3101; 41 CFR 101-11.6; 5 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

40 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
20 and supplies you received are covered by these programs and to insure that proper payment is made.

0 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.

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.

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, 55 Fed. Reg. 15111-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

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.

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
administration, 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.

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.

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, and documents or concealment of material facts may be prosecuted under applicable Federal or State laws.

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.

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