

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Be advise that before a bill can be considered "acceptable" for payment by the Victim Compensation and Government Claims Board, the following sections must be completed correctly or the bill will be returned and payment may be delayed

Section Number on CMS 1500 Form	Information listed below is needed in each section to process your bill
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1A* & 23*	VCP Claim Number/Insured's ID Number
2	Claimant's Name
5	Claimant's/Patient's address
21 & 24E	Diagnosis Codes
24A	Dates of Services
24D	Procedure Codes
24K	Intern Name & Registration Number
25	Tax Id/SSN/FEIN Number of Payee as Registered with IRS
28	Total Charges/Billed Amount
31	Provider/Treating/Supervising Therapist's Name, License Number, Signature/Signature stamp and date
32	Name & address where services rendered if different than box 33
33	Provider/Payee's Name as Registered with IRS, address & phone number

*Claim Number is not required if not listed.

ATTENTION ALL PROVIDERS ALREADY IN OUR SYSTEM: Number 25 and Number 33 on your bill must match exactly to what is in the system. If YOU/PROVIDER has a new Tax Id please notify the Program immediately

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BUK LUNG (SSN) OTHER

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **1A***

5. PATIENT'S ADDRESS (No., Street) **5**

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

8. PATIENT STATUS Single Married Other

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

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) b. AUTO ACCIDENT? c. OTHER ACCIDENT?

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or Pregnancy) (M.P.)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? \$ CHARGES

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

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER **23***

DATE(S) OF SERVICE From To	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR Family Plan	EMG	DOB	RESERVED FOR LOCAL USE
24A			24D	24E					24K

26. FEDERAL TAX I.D. NUMBER **25** SSN EIN

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

28. TOTAL CHARGE \$ **28**

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.) **31**

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

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # **33**

SIGNED DATE PINK GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 888) PLEASE PRINT OR TYPE FORM HCFA-1600 (12-93). FORM FRB-1600. FORM OWP-1600