| DI EACE  |   |   | •  |   |  |                       | APP                   | ROVED                                  | OMB-0938-00                             | 80       |
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| PLEASE<br>DO NOT   |   |   |  |   |  |                       |                       |  |   |          |
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| TTPICA   |   |   | <u> </u>   | <b>HEALTH INS</b>                       | SURANCE (                                | CLAIM                 | <b>FORM</b>           |  | PICA                                    |          |
| A STATE OF THE PARTY OF THE PAR | ICAID CHAMPUS                               | CHAN  | APVA GROUP FE  | CA OTHER                                | 1a. INSURED'S I.D.                       | NUMBER                | ,                     | (FOR PR                                | OGRAM IN IT                             | ΓΕΜ 1)   |
|  |   |   | HEALTH PLAN BL   | K LUNG<br>(SSN) (ID)                    |  |                       |                       |  |   |          |
|  | licaid #) Sponsor's S                       |   |  | (15)                                    | A INCUIDEDICAIAN                         | IT /I not blom        | na Eirat Nama         | Middle                                 | oitial\                                 |          |
| 2. PATIENT'S NAME (Last I  | Name, First Name, Middle I                  | nitial)   | 3. PATIENT'S BIRTH DATE<br>MM   DD   YY  | SEX                                     | 4. INSURED'S NAM                         | E (Last Nan           | ne, riist Name,       | Middle                                 | illiai)                                 |          |
|  |   |   | M  | bandband                                |  |                       |                       |  |   |          |
| 5. PATIENT'S ADDRESS (N  | lo., Street)                                |   | 6. PATIENT RELATIONSHIP 1  | TO INSURED                              | 7. INSURED'S ADD                         | RESS (No.,            | Street)               |  |   |          |
|  |   |   | Self Spouse Chil   | d Other                                 |  |                       |                       |  |   |          |
| DITY   |   | Ist   | ATE 8. PATIENT STATUS  |   | CITY                                     |                       |                       |  | STAT                                    | ΓE       |
| <i>/</i> 111   |   | 0"  |  |   | 1  |                       |                       |  |   |          |
|  |   |   | Single Married   | Other                                   |  |                       | Trevenuo              | E (INO) 1                              | IDE ADEA CO                             | 2051     |
| IP CODE  | TELEPHONE (Inclu                            | de Area Code)   | Foodbased on Forth Times   | Dark Time                               | ZIP CODE                                 |                       | I ELEPHON             | E (INCL                                | JDE AREA CO                             | JUE)     |
|  | 1 ( )                                       |   | Employed Full-Time Student   | Part-Time<br>Student                    |  |                       | (                     | )                                      | ,                                       |          |
| OTHER INSURED'S NAM  | //E (Last Name, First Name                  | , Middle Initial)   | 10. IS PATIENT'S CONDITION   |   | 11. INSURED'S PO                         | LICY GROU             | IP OR FECA N          | UMBER                                  | *************************************** |          |
|  |   |   |  | •                                       |  |                       |                       |  |   |          |
| OTHER INCHESTOR SOL  | ICV OR GROUP ALL MAREE                      | }   | a. EMPLOYMENT? (CURREN   | T OR PREVIOUS)                          | a. INSURED'S DAT                         | F OF BIRTL            | ł                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | OEV .                                   |          |
| . OTHER INSURED S POL  | ICY OR GROUP NUMBER                         | •   |  |   | a. INSONEDS DAT                          | DD   PYY              | M                     | -                                      | SEX<br>F [                              | 7        |
|  |   |   | YES  | NO                                      |  |                       |                       | <u> </u>                               |   |          |
| OTHER INSURED'S DAT  | E OF BIRTH SEX                              |   | b. AUTO ACCIDENT?  | PLACE (State)                           | b. EMPLOYER'S NA                         | AME OR SC             | HOOL NAME             |  |   |          |
| MM   DD   YY   | м   | F   | YES  | NO L                                    |  |                       |                       |  |   |          |
| . EMPLOYER'S NAME OR   | SCHOOL NAME                                 |   | c. OTHER ACCIDENT?   |   | c. INSURANCE PLA                         | N NAME O              | R PROGRAM I           | VAME                                   |   |          |
|  |   |   | T YES T  | NO                                      |  |                       |                       |  |   |          |
|  | 5 00 00000 WWW.                             |   | 10d. RESERVED FOR LOCAL  |   | A ICTUEDE ANOT                           | UED HEALT             | TH DENICEIT D         | ANIO                                   |   |          |
| . INSURANCE PLAN NAM   | E OR PROGRAM NAME                           |   | 10d. HESERVED FOR LOCAL  | . USE                                   | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? |                       |                       |  |   |          |
|  |   |   |  |   | YES                                      | NO                    | If yes, return        | -                                      |   |          |
|  |   |   | ETING & SIGNING THIS FORM.   | , ,                                     | 13. INSURED'S OR                         |                       |                       |  |   |          |
| 2. PATIENT'S OR AUTHO  | RIZED PERSON'S SIGNAT                       | TURE I authorize  | e the release of any medical or other in<br>either to myself or to the party who acc | ntormation necessary<br>ents assignment | payment of med<br>services describ       |                       | to the undersi        | ned phys                               | sician or supp                          | lier for |
| below.   | iso request payment or gove                 | THINGIN BOTTOMO   | onlier to mycom or to the party will also  | opio audignitioni                       | Joi vices describ                        | 00 00,000             |                       |  |   |          |
|  |   |   |  |   |  |                       |                       |  |   |          |
| SIGNED   |   |   | DATE   |   | SIGNED                                   |                       | and the second second |  | PROPERTY OF STREET                      |          |
| 4. DATE OF CURRENT:  | ILLNESS (First symptor INJURY (Accident) OR | n) OR   | 15. IF PATIENT HAS HAD SAME O  | R SIMILAR ILLNESS.<br>D   YY            | 16. DATES PATIEN                         | T UNABLE '<br>DD   YY |                       | MM I                                   | T OCCUPATE<br>DD   YY                   | ON       |
| WIW DD 111   | PREGNANCY(LMP)                              |   |  |   | FROM                                     | 1                     | TC                    |  |   |          |
| 7. NAME OF REFERRING   | PHYSICIAN OR OTHER S                        | OURCE   | 17a. I.D. NUMBER OF REFERRING  | PHYSICIAN                               | 18. HOSPITALIZAT                         | ION DATES             | RELATED TO            | CURRE                                  | NT SERVICES<br>DD   YY                  |          |
|  |   |   |  |   | FROM                                     | ''                    | TC                    |  |   |          |
| 9. RESERVED FOR LOCA   | J LISE                                      |   | 1  |   | 20. OUTSIDE LAB?                         |                       | \$ CHA                | RGES                                   |   |          |
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| 1. DIAGNOSIS OR NATUR  | RE OF ILLNESS OR INJUR                      | Y. (RELATE ITE  | EMS 1,2,3 OR 4 TO ITEM 24E BY LIN  | (E) —                                   | 22. MEDICAID RES<br>CODE                 | OBMISSION             | ORIGINAL F            | EF. NO.                                |   |          |
| . 1  |   |   | ه ا  | <b>Y</b>                                |  |                       |                       |  |   |          |
| 1  |   |   | J. L   |   | 23. PRIOR AUTHOR                         | RIZATION N            | IUMBER                |  |   |          |
| - 1  |   | •   | 4 1  |   |  |                       |                       |  |   |          |
| 2<br>4. A  | Т В   | C.  | 4. L   | 7 · E                                   | F  | G                     | HII                   | TJT                                    | К                                       |          |
| DATE(S) OF SE  |   | Type PROCI  | EDURES, SERVICES, OR SUPPLIES  |   | <u> </u>                                 | DAYS                  | EPSDT                 | ┌┷┼                                    | RESERVED                                | FOR      |
|  |   | of (I   | Explain Unusual Circumstances)   | CODE                                    | \$ CHARGES                               | UNITS                 | Family EMG            | COB                                    | LOCAL L                                 |          |
| MM DD YY MI  | M DD YY Service                             | Service CP1/I   | HCPCS   MODIFIER   |   |  | 5.17,5                |                       | $\vdash$                               |   |          |
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| 5. FEDERAL TAX I.D. NU   | MBER SSN EIN                                | 26. PATIEN  | IT'S ACCOUNT NO. 27, ACCE  | PT ASSIGNMENT?                          | 28. TOTAL CHARGE                         | E 29                  | 9. AMOUNT PA          | (ID                                    | 30. BALANCI                             | E DUE    |
|  |   |   | (For go  | vt. claims, see back)                   | s  |                       | <b>S</b>              |  | \$                                      | !        |
|  |   |   |  |   | 1  |                       |                       | <u> </u>                               |   | DE.      |
| <ol> <li>SIGNATURE OF PHYSI<br/>INCLUDING DEGREES</li> </ol>   |   |   | AND ADDRESS OF FACILITY WHER   | E SERVICES WERE                         | 33. PHYSICIAN'S, S<br>& PHONE #          | SUPPLIER'S            | BILLING NAM           | E, AUDR                                | iess, ZIP CO                            | UE       |
| (I certify that the stateme  | ents on the reverse                         | RENUE   | •  |   | G ( GOME #                               |                       |                       |  |   |          |
| apply to this bill and are   |   |   |  |   | 1  |                       |                       |  |   |          |
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|  | DATE  |   |  |   | PN=                                      |                       | GRP#                  |  |   |          |