MAPB-087-015-B/062-MA
Date: 9/1/87

Speech Therapy Services

FORM APPROVED
OMB NO 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO) [T] MEDICAID (MEDICAID NO) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO) [ ] FECA BLACK LUNG (SSN) [ ] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.

2 PATIENT'S DATE OF BIRTH: MM | DD | YY

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725

TELEPHONE NO

5 PATIENT'S SEX: MALE [X] FEMALE [ ]

6 INSURED'S I.D. NO (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS): 1234567890

7 PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]

8 INSURED'S GROUP NO (OR GROUP NAME OR FECA CLAIM NO)

[ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - P

10 WAS CONDITION RELATED TO:
A PATIENT'S EMPLOYMENT: YES [ ] [X] NO
B ACCIDENT: AUTO [ ] [ ] OTHER

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO

11a CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED; BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL 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 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES / / / / / / / / / /

16a IF EMERGENCY CHECK HERE

17 DATE PATIENT ABLE TO RETURN TO WORK / / / / / / / /

18 DATES OF TOTAL DISABILITY: FROM / / / / / / / / / / THROUGH / / / / / / / / / /

DATES OF PARTIAL DISABILITY: FROM / / / / / / / / THROUGH / / / / /

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): I. M. Prescribing 12345678

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): I. M. Nursing Home 12345678

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1. 784.5
2. 389.9
3.
4.

B EPSDT: YES [ ] [X] NO
FAMILY PLANNING: YES [ ] [X] NO

PRIOR AUTHORIZATION NO: 1234567

24 A DATE OF SERVICE FROM / TO	B PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G TOS	H LEAVE BLANK
02/02/88	8	92507	Speech/Language Therapy 30 min. ea.	1,2	XX XX	1.0	1	
03/01, 02, 03, 04/88	8	92508	Group Therapy 4 in group 30 min. ea.	1,2	XX XX	4.0	1	
			I. M. Performing 12345678					
								Patient Spenddown $

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

DATE MM/DD/YY I.M. PROVIDER

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): / / YES [ ] / [ ] NO / /

27 TOTAL CHARGE: XX XX

28 AMOUNT PAID: XX XX

29 BALANCE DUE: XX.XX

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO:
I.M. Billing
1 W Williams
Anytown WI 53725
ID NO 87654321

32 YOUR PATIENT'S ACCOUNT NO: 1234JED

33 YOUR EMPLOYER I.D. NO / / / / / / / / / / / / / /

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500