ATTACHMENT 1

MAPB-087-006-P
Date 9/1/87

Family Planning Services

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO) [P] 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 [ ] FEMALE [X]

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 - R

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

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)

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 V25.1
2 V25.4
3
4

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

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
01/30/88	3	W6200	IUD	1	XXXX	1.0	9	
02/22/88	3	90040	OFFICE VISIT	2	XXXX	1.0	9	
								Patient Spenddown S

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
CHAMPUS-501 Form RRB-1500