Attachment 1a

MAPB-087-008-K
Date 9/1/87

Independent Laboratory 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 [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 [ ] NO [X]
    B. ACCIDENT: AUTO [ ] OTHER [X]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
    TELEPHONE NO.
    11.a 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 /
16.a 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. REFERRING 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 V726
    2
    3
    4
    B. EPSDT YES [ ] NO [X]; FAMILY PLANNING YES [ ] NO [X]
    PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM TO	B. * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. * T.O.S.	H. LEAVE BLANK
02/02,17,28/88	A	82947	Glucose	1	XX XX	3.0	5	
02/15/88	A	83526	I.T.T.	1	XX XX	1.0	5	
02/21/88	7	P9000-Z1	Out of zone pick-up	1	XX XX	1.0	5	
02/21/88	7	P9000	Drawing Blood	1	XX XX	1.0	5	
								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
    I.D. NO. 87654321
32. YOUR PATIENT'S ACCOUNT NO. 1234JED
33. YOUR EMPLOYER I.D. NO. /

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) 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

790-002 / (2-PLY)