PLEASE
DO NOT
STAPLE
IN THIS
AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

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

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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

1. ____ . __
2. ____ . __
3. ____ . __
4. ____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

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.)

SIGNED DATE

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

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

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500,
FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Audit Tool (1995 or 1997 Guidelines)

Chief Complaint:

HISTORY

HPI (history of present illness)		Brief 1-3 elements	Brief	Extended ≥ 4 elements or ≥ 3 chronic conditions	Extended status of or inactive
☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms					
ROS (review of systems)		None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems, or some systems with statement "all others negative"
☐ Constitutional (wt loss, etc) ☐ Ears, nose, mouth, throat ☐ GI ☐ GU ☐ Integumentary (skin, breast) ☐ Endo ☐ Hem/lymph ☐ Eyes ☐ Card/vasc ☐ Musculo ☐ Neuro ☐ All/imm ☐ Resp ☐ Psych ☐ "All others negative"					
PFSH (past family and social history) ☐ Past medical history ☐ Family history ☐ Social history	Established/ ER	None	None	One history area	Two or three history areas
No PFSH required: 99231-33	New/ Consult/ Admit	None	None	One or two history area(s)	Three history areas
Circle the entry farthest to the right for each history area. To determine history level, draw a line down the column with the circle farthest to the left.		PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

1995 EXAM

Organ systems:	Body area or system related to problem	2 - 4 systems	5 - 7 systems	8 or more systems
☐ Constitutional (e.g. vitals, gen app) ☐ Ears, nose, mouth, throat ☐ Resp ☐ Musclo ☐ Psych ☐ Eyes ☐ Cardiovascular ☐ GI ☐ Skin ☐ Hem/lymph/imm ☐ GU ☐ Neuro				
	PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

COMPLEXITY

A Number of Diagnoses or Treatment Options

Problems to Exam Physician	Number	X Points	= Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New problem (to examiner); add. workup planned		4	
		TOTAL	

Bring total to line A in Final Result for Complexity

B Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Bring total to line B in Final Result for Complexity

FINAL RESULT OF COMPLEXITY

Draw a line down the column with 2 or 3 circles and circle decision making level OR Draw a line down the column with the center circle and circle the decision making level.

A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Moderate	≥ 4 Extensive
C	Highest risk	Minimal	Low	Moderate	High
	Type of decision making	STRAIGHT-FORWARD	LOW COMPLEX	MODERATE COMPLEX	HIGH COMPLEX

C Risk of Complications and/or Morbidity or Mortality

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, *e.g. cold, insect bite, tinea corporis*	• Laboratory tests requiring venipuncture • Chest x-rays • KOH prep • EKG/EEG • Urinalysis • Ultrasound, *e.g. echo*	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, *e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH* • Acute uncomplicated illness or injury *e.g. cystitis, allergic rhinitis, simple sprain*	• Physiologic test not under stress, *e.g. pulm. function tests* • Non-cardiovascular imaging studies with contrast, *e.g. barium enema* • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identifi[ed] risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, *e.g. lump in breast* • Acute illness with systemic symptoms, *e.g. pyelonephritis, pneumonitis, colitis* • Acute complicated injury, *e.g. head injury with brief loss of consciousness*	• Physiologic test under stress, *e.g. cardiac stress test, fetal contraction stress test* • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, *e.g. arteriogram, cardiac cath* • Obtain fluid from body cavity, *e.g. lumbar puncture, thoracentesis, culdocentesis*	• Minor surgery with identified risk factors • Elective major surgery (oper[n], percutaneous or endoscopic) with no identified risk factors • Prescription drug manageme[nt] • Therapeutic nuclear medicin[e] • IV fluids with additives • Closed treatment of fracture dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression or side effects of tx • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, *e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure* • An abrupt change in neurological status, *e.g. seizure, TIA,*	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (ope[n], percutaneous or endoscopic) with identified risk factor • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxic[ity] • Decision not to resuscitate or de-escalate care because of poor prognosis

Transfer the history, exam and medical decision making results to the appropriate chart below and follow the specific instructions for that chart.

KEY: *PF* = Problem focused; *SF* = Straightforward; *EPF* = Expanded Problem Focused; *L* = Low; *M* = Moderate; *D* = Detailed; *H* = High; *C* = Comprehensive

LEVEL OF SERVICE

Outpatient Visits and Consultations

	New/Consults					Established				
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	*Minimal problem that may*	PF	EPF	D	C
Examination	PF	EPF	D	C	C	*not require presence*	PF	EPF	D	C
Complexity of medical decision	SF	SF	L	M	H	*of physician*	SF	L	M	H
New Patient Outpatient consult Inpatient Consult	99201-10 99241-15 99251-20	99202-20 99242-30 99252-40	99203-30 99243-40 99253-55	99204-45 99244-60 99254-80	99205 - 60 99245 - 80 99255-110	99211 5	99212 10	99213 15	99214 25	99215 40

Inpatient

	Initial Hospital/Observation			Subsequent Inpatient		
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF Interval	EPF Interval	D Interval
Examination	D or C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Admission OBS Admit Sameday Admit & DC	99221-30 99218-N/A 99234-N/A	99222-50 99219-N/A 99235-N/A	99223-70 99220-N/A 99236-N/A	99231-15	99232-25	99233-35

ER

	ER				
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.				
History	PF	EPF	EPF	D	C
Examination	PF	EPF	EPF	D	C
Complexity of medical decision	SF	L	M	M	H
	99281-N/A	99282-N/A	99283-N/A	99284-N/A	99285-N/A

TIME

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time? Time: Face-to-face in outpatient setting / Unit/Floor in inpatient setting	☐ Yes	☐ No
Does documentation describe the content of counseling or coordinating care?	☐ Yes	☐ No
Does documentation reveal that more than half of time was counseling or coordinating care?	☐ Yes	☐ No

If all answers are "yes," may select level based on time