Treatment day "0"

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) 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 Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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 _____

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DAT MM DD FROM

19. RESERVED FOR LOCAL USE

Six units of 15 minute increments for CPT 97039 billed

20. OUTSIDE LAB? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. C50.11

2.

3.

4.

22. MEDICAID RESUBMISS CODE

THORIZATIO

Example: principal diagnosis of C50.11 - malignant neoplasm; central portion breast, female. However, ICD10CM diagnosis could be any in the C50 series for breast cancer.

Modifier "51" reflects multiple procedures

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
1						22		97039	51		$1,200.00			NPI	
2														NPI	
3														NPI	
4														NPI	
5															
6															

Site of service:"22" hospital outpatient setting. Alternatively could be "11" physician office setting.

CPT 97039 - physical medicine; unlisted modality. Definition of physical medicine: any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal medicine. This code would be used for Dignicap scalp hypothermia system. Dignicap requires direct supervision during its application. Bill in 15 minute increments.

Include physician charge for CPT 97039 - charge for this code assumes a cost to charge ratio of 0.33; i.e. cost = $400/0.33 = $1,200; this is reflective of 6 fifteen minute sessions or a total use of 1.5 hours. Each fifteen minute increment is charged at $200 and reimbursed at $67.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER

28. $

ANCE 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. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33.

a.